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Ontario

ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence  
for

MARCH 1, 1984

VOLUME 113

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Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Thursday, the 1st  
day of March, 1984.

- - - -


THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

- - - -

APPEARANCES:

E. CRONK	Commission Counsel
D. HUNT )	Counsel for the Attorney
L. CECCHETTO )	General and Solicitor General
	of Ontario (Crown Attorneys
	and Coroner's Office)
I.G. SCOTT, Q.C. )	Counsel for The Hospital for
I.J. ROLAND )	Sick Children
R. BATTY )	
B. PERCIVAL, Q.C. )	Counsel for The Metropolitan
D. YOUNG )	Toronto Police
K. CHOWN	Counsel for numerous Doctors
	at The Hospital for Sick
	Children
E. McINTYRE	Counsel for the Registered
	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children
H. SOLOMON	Counsel for The Ontario
	Registered Nursing Assistants

(Cont'd)



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APPEARANCES (CONTINUED)

J. SOPINKA, Q.C. ) Counsel for Susan Nelles -  
D. BROWN ) Nurse

E. FORSTER Counsel for Phyllis Trayner -  
Nurse

J.A. OLAH Counsel for Janet Brownless -  
R.N.A.

B. JACKMAN Counsel for Mrs. M. Christie -  
R.N.A.

S. LABOW Counsel for Mr. & Mrs. Gosselin,  
Mr. & Mrs. Gionas, Mr. & Mrs.  
Inwood, Mr. & Mrs. Turner, Mr. &  
Mrs. Lutes, and Mr. & Mrs.  
Murphy (parents of deceased  
children)

F.J. SHANAHAN Counsel for Mr. & Mrs. Dominic  
Lombardo (parents of deceased  
child Stephanie Lombardo); and  
Heather Dawson (mother of  
deceased child Amber Dawson)

W.W. TOBIAS Counsel for Mr. & Mrs. Hines  
(parents of deceased child  
Jordan Hines)

J. SHINEHOFT Counsel for Lorie Pacsai and  
Kevin Garnet (parents of  
deceased child Kevin Pacsai).

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DM/ko

1  
2 --- Upon commencing at 10:00 a.m.

3 ELIZABETH RADOJEWSKI, Resumed

4 THE COMMISSIONER: Yes, Mr. Percival.

5 MR. PERCIVAL: Mr. Commissioner, I  
6 understand that a poll was taken yesterday afternoon  
7 after I left, and I was doing a mental interpretation  
8 and I have some extreme difficulties on Monday  
9 morning, because it looks like I would not get  
10 reached today in view of what Mr. Hunt said of at  
11 least two hours.

12 MR. HUNT: I said at the most two  
13 hours.

14 MR. PERCIVAL: My problem is this,  
15 I can't be here on Monday or Tuesday because of the  
16 Law Reform Commission.

17 THE COMMISSIONER: I am looking at  
18 Mr. Hunt, and I am wondering if perhaps we could fit  
19 you in --

20 MR. PERCIVAL: I am quite happy to go  
21 wherever you put me.

22 THE COMMISSIONER: Or even Mr. Brown.

23 MR. BROWN: I have informed Mr.  
24 Percival that I have no objection to him preceding  
25 me.

THE COMMISSIONER: Ms. Forster?





1  
2 MS. FORSTER: No I don't, sir.

3 THE COMMISSIONER: Mr. Hunt?

4 MR. HUNT: The only problem is I was  
5 going to have to leave early this afternoon for  
6 another matter at 4 o'clock.

7 THE COMMISSIONER: It might shorten  
8 your cross-examination.

9 MR. HUNT: I might be able to shorten  
10 it even without Mr. Percival's help, but if he goes  
11 first that is going to put me into difficulty later  
12 this afternoon.

13 THE COMMISSIONER: What would you  
14 think of this: as soon as Ms. McIntyre finishes you  
15 go, and then we call Mr. Percival and that will  
16 probably mean that - and we will sit as long as is  
17 necessary to finish you off today, is that all right  
18 with you Ms. Forster and Mr. Brown? That means you may  
19 not come on until Monday. All right?

20 MR. PERCIVAL: Fine, thank you.

21 THE COMMISSIONER: Okay.

22 MS. McINTYRE: Mr. Commissioner, I am  
23 still working on the possibility of being available  
24 tomorrow, I should know later on this morning, I am  
25 trying to rearrange things, you had mentioned some  
possibility of wanting to continue tomorrow.







1  
2 THE COMMISSIONER: Oh well, yes. I  
3 thought that had been abandoned. I guess we  
4 abandoned it because of you.

5 MS. McINTYRE: Well, that's right,  
6 no one else objected and I am making efforts to  
7 dispose of the other matter that I have tomorrow and  
8 I will let you know later on this morning.

9 THE COMMISSIONER: What is your  
10 position, you are in trouble?

11 MS. FORSTER: Mr. Commissioner, I  
12 didn't object yesterday because Ms. McIntyre made an  
13 objection. My difficulty is, and I think the  
14 difficulty of several Counsel, that we do have other  
15 commitments that we made months ago because our only  
16 free day is Friday, so it makes it kind of difficult.

17 THE COMMISSIONER: I think, Ms.  
18 McIntyre, we will just have to leave it that way,  
19 because there are too many people that are going to  
20 be affected by it. But next Friday is a problem.  
21 I have already warned both Miss Cronk and Mr. Olah  
22 that we may, if we get to the point where Janet  
23 Brownless, as we just have the re-examination, we are  
24 certainly going to go on with that on Friday of next  
25 week, and I thought we might sit early and late to  
avoid the rest of you having to be here on the Friday,





1  
2 but it may not work.

3 MR. PERCIVAL: Mr. Commissioner, you  
4 won't believe how brief people will be if they want  
5 to get away.

6 THE COMMISSIONER: Maybe that is the  
7 thing, and of course I have that glorious stopwatch,  
8 I can always bring that into play again. At any rate,  
9 all I can do is make some warning about next Friday  
10 and maybe just the warning will be sufficient to make  
11 sure we don't have to sit next Friday.

12 MS. McINTYRE: That seems fair.

13 THE COMMISSIONER: I think you can  
14 just leave your arrangements as they are and we  
15 won't sit tomorrow.

16 MS. McINTYRE: Thank you, Mr.  
17 Commissioner.

18 First of all, Mr. Commissioner, I  
19 have located the original of Exhibit No. 368 that  
20 Ms. Cronk was asking for yesterday. I don't know  
21 if she wishes to ask more questions on that now, or  
22 whether she wishes to leave it until a later time.

23 MS. CRONK: No, we can check that  
24 out later, but I would like it marked in lieu of  
25 the copy that was presented.

MS. McINTYRE: I apologize, I didn't







1  
2 have it with me yesterday.

3 THE COMMISSIONER: We will just  
4 replace the one with the other. Yes, Ms. McIntyre?

5 MS. MCINTYRE: Thank you.

6 EXAMINATION BY MS. MCINTYRE: (Continued)

7 Q. Yesterday, Mrs. Radojewski, I  
8 was asking you about your impression of the death  
9 rate on Ward 5A prior to the period we are examining  
10 here, and you quite rightly pointed out we do have  
11 actual data before the Commission. I would like to  
12 refer you briefly to Exhibit 125. Mr. Registrar, if  
13 you could get that exhibit please.

14 This I believe sets out the monthly  
15 examination of the death rate from 1976 until 1982.  
16 Prior to the period in question the blue line I  
17 believe Mrs. Radojewski reflects the death rate on  
18 Ward 5A, and it shows considerable fluctuation  
19 between zero and up to five, with most months being  
20 two or three. Does that accord with your impression  
21 of the death rate on 5A?

22 A. Yes, it does.

23 Q. And with respect to all cardiac  
24 deaths, which I believe was to represent all deaths  
25 in the hospital in which cardiology had been involved,  
it is the red line, and that shows also considerable





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fluctuation from between one I believe in 1979 up to somewhere around 14 or 15; would that accord as well with your impression?

A. If all cardiac includes patients that were on the wards other than 5A and Intensive Care and ICU, I would only have limited knowledge of the other areas.

Q. Okay.

A. But it does seem like a valid impression.

Q. Thank you. Now you have told us with respect to the deaths on Ward 4A and 4B that you would have been informed of those deaths that occurred while you were absent from the floor, is that right?

A. Yes.

Q. Any deaths that occurred during the night, just prior to when you came on duty, how would you be informed of those deaths?

A. Usually on an informal basis, in the few minutes before we actually went into our formal report, the nurses would tell me that there had been an arrest during the night, and then I would hear about it in report as well.

Q. It would be in the report, the







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formal report in the morning?

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A. Yes.

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Q. What about those deaths that occurred in a night, and then you were away for several days, how would those come to your attention?

7

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A. Those were brought to my attention in more of an informal way, in that if I was off for several days they would not necessarily be mentioned in report.

10

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Q. Would the chart necessarily be available for you to review after the child had died?

12

A. No, it wasn't.

13

14

Q. What happened to the chart when a child arrested?

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A. The chart was to be completed by the end of the shift when the death had occurred, and it was delivered to medical records, as soon as it was completed, it was not to remain on the ward.

18

19

Q. Now in the case of Pacsai, you did review the chart after the death, would that normally be the case?

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A. No, that was very unusual.

Q. Now we know that the death was reported on the tour end report, and I believe also on the WIN sheets, is that correct?





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A. Yes.

Q. Other than those two documents were you required to submit any formal report of the death?

A. No, I was not.

Q. Other than the September meetings with Dr. Rowe, would you have attended any other meetings to discuss the deaths with the physicians? On a routine basis would you have met with the doctors to discuss the individual deaths?

A. No.

Q. And what role would you or your nursing staff have in examining the cause of death with respect to an individual patient?

A. There was very little role that we played in examining the cause of death.

Q. Who did you understand had that responsibility?

A. That was the responsibility of the physician in charge of the patient.

Q. Would there be any circumstances that would lead you to question the cause of death?

A. No.

THE COMMISSIONER: Surely that -  
neither the question nor the answer was thought out very





1  
2 carefully.

3 MS. MCINTYRE: Q. Let me ask the  
4 question again. If your staff nurses raised with you  
5 a concern with respect to why a child died, would you  
6 pursue that?

7 A. Yes, I would.

8 Q. And how would you do that?

9 A. We were taking our concerns with  
10 any - any concern about the patients first of all to  
11 the cardiology fellow in charge of the ward, that was  
12 our first step.

13 Q. But I take it that would not  
14 be done on a routine basis unless there was some  
15 reason for you to question a death?

16 A. Yes, unless there was some  
17 reason.

18 THE COMMISSIONER: What I was objecting  
19 to, would there be any circumstances where you would  
20 question the death of the child, and the answer came  
21 no, I don't really believe that you or Mrs. Radojewski  
22 have thought out that question, because surely there  
23 would be all kinds of circumstances where you would  
24 question the death of a child and we have heard about  
25 all sorts of circumstances where they have done that.

MS. MCINTYRE: That is why I wanted to







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re-phrase the question, Mr. Commissioner.

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THE COMMISSIONER: Yes. All right.

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MS. McINTYRE: Thank you for

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pointing that out.

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MS. McINTYRE: Thank you for pointing  
that out.

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Q. I take it you did not receive  
a copy of the post mortem report?

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A. No, we did not.

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Q. Were you normally told what  
the results of the post mortem results were?

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A. We would have to ask the  
doctor, we would have to seek the answer from the

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13

MS. CRONK: Sir, I'm sorry to rise.  
Was that question, those two questions directed to  
any particular child or were they general questions?

14

15

MS. McINTYRE: These are general  
questions.

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MS. CRONK: Then perhaps that could  
be put to the witness so that it is clarified.

18

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20

MS. McINTYRE: Q. Mrs. Radojewski,  
I take it in the September meetings there were some  
particular post mortem results brought to your  
attention?

21

A. Yes.

22

23

Q. And as well in July there were  
some particular results brought to your attention?

24

25

A. Yes.







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Q. And that arose as a result of  
your questioning?

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A. Yes.

5

Q. But as a routine matter they  
would not be, is that right?

6

A. No, generally they were not.

7

8

Q. And I take it that the rationale  
behind the mortality and the morbidity conferences  
was to make nurses more aware of these results?

10

A. Yes, it was an ongoing learning  
process for them, it is a way of learning.

11

12

Q. With respect to individual  
deaths, was there any follow-up that you would do  
with other staff members or other personnel from  
the Hospital on a routine basis?

13

14

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A. Other than physicians, I would  
ask the public health nurse to make a referral to  
the community if they were outside of her juris-  
diction, to make a visit to the home to see if the  
family was coping.

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Q. And how would that be done?

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A. We had multi-disciplinary  
meetings every Wednesday and as the patient's  
names - I would review the patient's names on a  
series of cards and when we came to a patient who

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1  
2 had died I would ask Miss Janine Beaudoin to make the  
3 referral.

4 Q. And what was the purpose of  
5 that referral?

6 A. It was really about the only  
7 thing we could do in nursing to follow up, to make  
8 sure the families were coping and how they were  
9 managing with their grieving process. Carol Browne  
10 also had some contact with the families as well  
11 after the children had died and she would pass on  
the information that she knew.

12 Q. I take it in July of 1980  
13 from your evidence that your focus was not the cause  
14 of these deaths as much as the impact of them on  
your staff, is that right?

15 A. Yes, it was a pretty horrendous  
16 summer for the staff that we had.

17 Q. Can you explain why you would  
18 be concerned about the impact on the staff?

19 A. We had several new staff  
20 members, meaning they had no previous experience  
21 at all, they were hired fresh from nursing school,  
22 fresh from their university training and you don't  
23 expect them to run into such a busy time and such  
24 a stressful time and I was worried that the experience  
25





Radojewski, ex.  
(McIntyre)

5457

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2 may be detrimental. I didn't want them to feel that  
3 their very first experience as a registered nurse  
4 was a bad one and I was worried that they could cope  
5 with their feelings about death and dying and  
6 grieving for patients and yet be able to function as  
7 nurses as well.

8 Q. As the head nurse in charge of  
9 the nursing staff on that unit, what areas of concern  
10 would you have with respect to how nurses functioned  
11 in an arrest situation?

12 A. I would be concerned that they  
13 first of all could recognize and assess an arrest  
14 situation, call the appropriate code as quickly as  
15 possible, initiate the resuscitation on their own  
16 and then in turn prepare for the team, the  
17 resuscitation team to come on the ward and throughout  
18 the arrest to anticipate their needs.

19 Q. And during the period in  
20 question did you have any reason to think that your  
21 nursing staff was not functioning properly with  
22 respect to these responsibilities?

23 A. Could you repeat the first part  
24 of that please.

25 Q. During this period in question  
from July of '80 until March of '81 did you have any







5 reason to think that your nurses were not functioning properly with respect to these responsibilities?

A. No, I had no reason. If I can explain, the rapport that I had with the nursing supervisors on evenings and nights I felt confident if there were concerns that they saw they would be raised with me.

Q. And did you have any feedback from either the physicians or from the arrest team that there were problems in the way your nursing staff were functioning?

A. None that I can recall.

Q. You told Ms. Cronk that you were uncomfortable with the term of "unexpected", and you used the term "explained" with respect to a number of the children that she discussed with you. Can you explain, expand on what you mean by the term "explained"?

A. First of all, nurses do not expect their patients to die other than the terminally ill children that we have where there is a 'do not resuscitate' and "explainable" means that there is a reason for the death after the death.

Q. In your experience as a nurse, do you feel that you can always anticipate when a





Radojewski, ex.  
(McIntyre)

1  
2 patient will arrest?

3                   You cannot always anticipate.  
4 In paediatric cardiology and the length of time that  
5 I had worked in there, it was often, in my experience,  
6 my personal experience, the unexpected, for want of  
7 a better word, the unexpected child that would arrest  
8 on you. There were certain signs and symptoms in  
9 your assessment that might lead you to suspect that  
10 a child is getting into difficulty and may perhaps  
11 arrest.

12                   Q.       Was it your practice in  
13 preparing your tour end reports or preparing to  
14 leave for the day to review in your own mind which  
15 of your patients you expected to die?

16                   A.       I don't recall doing that,  
17 no.

18                   Q.       But I take it you did assess  
19 the condition of the patients for purposes of  
20 staff assignment?

21                   A.       Yes, I did.

22                   Q.       And that would include assess-  
23 ments with respect to whether a child required  
24 constant or shared nursing care?

25                   A.       That was taken into consideration  
in whether or not the child required a registered







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nurse or a registered nursing assistant to look after  
them.

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Q. How was the decision made, or  
who made the decision that the child would require  
constant nursing care?

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A. The decision was formally made  
by the resident or the physician in charge of the  
child. Very often there was a lot of nursing input  
and in reality we seemed to come to the conclusion  
often ourselves, there was a great deal of nursing  
input and it was not uncommon to seek the order for  
constant nursing care.

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Q. I take it a physician's  
order was required for constant nursing care for  
budget purposes?

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A. Yes, definitely.

16

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Q. What type of patient would, in  
your experience, be ordered constant nursing care?

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A. Patients who required a great  
deal of direct nursing observation or a great deal  
of treatment and patients who were of a critical  
nature or at risk of arresting where they needed  
very close observation.

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Q. Would all patients who needed  
constant nursing care necessarily be critically ill?





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A. No, not necessarily.

Q. And would all critically ill patients necessarily be subject to either constant or shared nursing care?

A. Can you repeat that?

Q. Would all patients who were critically ill necessarily be on constant or shared nursing care?

A. There would be instances when unfortunately they wouldn't be I think.

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Q Could you indicate what  
circumstances this might be?

A There would be short periods  
throughout the day. For instance, if a child returned  
from the cardiac cath lab and we did very frequent  
observation of the child, and for that short space  
of time the concept of constant nursing care or  
shared care would be in effect but there would be no  
order for it. It was just an understood thing that  
the child required that care for that short period  
of time in a day.

Q You told Ms. Cronk that the  
more seriously ill patients on 4A would be in Room 418.  
I take it that not all the patients in there would  
necessarily be seriously ill; is that correct?

A That is correct.

THE COMMISSIONER: That is the infant  
room, is it?

THE WITNESS: Yes.

THE COMMISSIONER: 418. The seriously  
ill patient who was not an infant; that is, over a  
year old, would not be in that room? Am I right or  
am I wrong?

THE WITNESS: That is a fair assumption.  
Really the deciding factor was anyone who was in a very







C.2

1  
2 large bed. There just physically was not room to  
3 have a very large bed in that room so that we could  
4 have a toddler who was still of crib size in that room.

5 MS. McINTYRE: Q. And if they were  
6 seriously ill that is where you would put a toddler?

7 A. Yes.

8 Q. And what if you had a seriously  
9 ill patient either an infant or a toddler who required  
10 isolation? I take it they would not be in 418?

11 A. If they required isolation, we  
12 had one single room on the ward that we used, unless  
13 they were - unless the whole room of 418 was in  
14 isolation.

15 Q. And the single room was 423 I  
16 believe, was it?

17 A. Yes.

18 Q. I want to ask you some questions  
19 about the giving of medications.

20 First of all, this Commission has heard  
21 evidence from Bertha Bell that she observed Phyllis  
22 Trayner administering an IV medication to Baby Miller  
23 when that patient was assigned to Susan Nelles. Can  
24 you tell us as the Head Nurse of the unit if there  
25 is anything improper in a team leader administering  
a medication for a staff nurse?





C.3

1  
2 A There is nothing improper. The  
3 understanding has always been in nursing that the team  
4 leader and the registered nurse that she is giving  
5 medication for have discussed it and the registered  
6 nurse very often has made the request to the team  
7 leader. And if she is busy with other things and  
8 the medication is due, "Could you please give it for  
9 me?"

9 Q So you were saying it is not  
10 improper as long as there is an understanding between  
11 the team leader and the nurse?

12 A Yes.

13 Q I take it you would not be  
14 surprised to see a team leader administering an IV  
15 medication to an RN's patient?

16 A As long as I had some knowledge  
17 of what the RN was doing.

18 Q You are saying if the RN was  
19 otherwise occupied?

20 A Yes.

21 Q If that was the case and you  
22 knew that the RN was otherwise occupied, would you  
23 take particular note if you observed a team leader  
24 administering a medication?

25 A No.





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Q I take it that you think it is not proper for the RN then to sign off that medication given by the team leader?

A I am not very pleased about that, no.

Q Can you think of any circumstances in which this may happen?

A It is basically sloppy practice, but if they are in a hurry to get off at the end of the shift, then it is possible that the RN who was caring for the patient just signs off the medications that were --

Q When were - I am sorry, are you finished?

A She would sign off medications that were to be given for that patient.

Q When were medications as a practice signed off on 4A?

A They were signed off usually at the end of the shift.

Q In theory, when is it best to sign for medications that have been given?

A In theory and ideally you sign for the medication after you have given it. Not several hours after but after you have administered it.







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Q But I take it that was not the practice on the floor?

THE COMMISSIONER: You mean it is not an ideal practice?

THE WITNESS: Yes.

THE COMMISSIONER: What is your answer to that? That it was not the practice?

THE WITNESS: I know it wasn't the practice. They did sign their medications off at the end of the shift, but it was the reality of the workplace; it was the availability of the charts for the registered nurse.

THE COMMISSIONER: What did you do yourself? I mean presumably you from time to time administered medication?

THE WITNESS: If I had administered medication I tried my utmost to sign them off after I had given them as the head nurse. Because I had so many other things to do --

THE COMMISSIONER: Yes.

THE WITNESS: -- I was afraid I would forget. But I know when I acted as team leader at Christmas time I am sure that I signed them at the end of the shift as well.

MS. MCINTYRE: Q I take it that the





C.6

1  
2 charts on 4A are kept at the nursing station; is  
3 that right?

4 A That is where they are kept.  
5 They are not always found there.

6 Q Is that where the charting is  
7 normally done by the nurses?

8 A Yes.

9 Q I understand that in the ICU  
10 unit, for example, there is a different practice  
11 where the charts are actually kept at the bedside?

12 A Yes.

13 Q Do you agree that that would  
14 make it easier for signing off medications as they  
15 were given?

16 A That would make it easier. I  
17 am unsure of the practicality on an open ward.

18 Q Can you explain that briefly?

19 A When you have children that are  
20 mobile, curious toddlers, older children, wandering  
21 in and out, they could pick up a chart and head off  
22 with it, or the chart is available for anyone to  
23 walk in and read, whereas in an ICU setting it is a  
24 much more controlled environment.

25 Q I see. How serious a violation  
would you as Head Nurse consider it to be if you

(2)





C.7

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discovered that one of your nurses had signed off  
a medication given by another RN?

3

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A. I am quite sure I would remind  
her.. I know I would remind her that it is not an  
accepted practice, but it is not a drastic measure.

5

6

7

Q. Would it in your view require  
some disciplinary response?

8

9

A. No.

10

11

Q. In the 4A medication room you  
kept ampules of digoxin, as I understand it, both  
adult and paediatric; is that right?

12

A. Yes.

13

14

Q. Can you give us any idea as to  
how frequently those ampules would be used as compared  
with elixir?

15

16

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A. The elixir was used daily for  
many of our patients. Intravenous dose was used when  
a child was - could have nothing by mouth and was  
unable to take their dose orally. The route of choice  
was an oral preparation. The intravenous doses were  
also used if we were digitalizing a very ill patient  
as well.

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Q. Could you give us any idea as  
to how frequently they were used? Once a week, once  
a month, daily?





C.8

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A. They are definitely not used daily. We might use one or two ampules every two weeks or one a week at the very most.

Q In your view if the ward was going through large numbers of ampules, a dozen in a month or more, do you think that would be detected in any way? I realize that this drug was not controlled as a narcotic. But do you think it would be noted if there were large numbers of ampules being used?

A I feel that it would be brought to my attention. The responsibility for ordering them, after we got our clinical pharmacist --

Q That was in September, 1980?

A Yes.







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DM/cr

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Q. I'm sorry if I interrupted you,

3

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A. It was their responsibility to order them and keep up our ward stock, and I am quite confident that she would have come to me had we been going through a large number.

5

6

7

MR. ROLAND: I am sorry, I missed the large number example.

8

9

THE COMMISSIONER: The large number ampules being used.

10

11

MR. ROLAND: What was the example?

12

MS. McINTYRE: A dozen in a month I

13

MR. ROLAND: A dozen in a month?

14

MS. McINTYRE: Yes.

15

16

Q. I am sorry, you felt confident that she would bring it to your attention, is that what you said?

17

18

A. Yes.

19

Q. Were you finished?

20

A. Yes.

21

Q. And did either you or your pharmacist, to your knowledge, notice that there was a large number of digoxin ampules being used?

22

23

A. No, I did not.

24

25





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3 Q. Did you have any concerns at  
4 any time about keeping digoxin ampules, both adult  
5 and paediatric, on the ward?

6 A. I was uncomfortable keeping the  
7 adult size ampule on the ward for fear that someone  
8 would make a miscalculation using an adult ampule.  
9 It was unusual for us to use the adult ampules unless  
10 we had a very large child indeed.

11 Q. And what do you mean by a  
12 miscalculation, what would you anticipate that might  
13 have been?

14 A. It is very easy in calculating  
15 your digoxin to misplace a decimal point. And we had  
16 had, in my experience, if I can explain this and  
17 this may make it sound easier, we had kept morphine  
18 10 milligrams per millilitre, and morphine one  
19 milligram per millilitre, and it is easy to make an  
20 error in placing a decimal point, and I felt that  
21 the adult ampule of digoxin it was the same.

22 Q. When you talk about --

23 THE COMMISSIONER: I am sorry, isn't  
24 there a difference between the appearance of an  
25 adult and a paediatric ampule?

THE WITNESS: Yes, there is, the adult  
ampule is a larger size.





Radojewski, ex.  
(McIntyre)

1  
2 THE COMMISSIONER: Yes, and we know  
3 it is much stronger. I don't quite understand your  
4 answer that it is easy to misplace a decimal.  
5 The real danger would be that they would use the  
6 adult instead of the infant, wouldn't that be the  
7 problem? That doesn't seem to have much to do  
8 with decimals.

9 THE WITNESS: We had a formula --

10 THE COMMISSIONER: Once they use the  
11 adult the damage is done, isn't that right?

12 THE WITNESS: Well you can use an  
13 adult ampule in preparing your IV dose of digoxin.

14 THE COMMISSIONER: But you have to,  
15 when you are using that you have to use a much  
16 smaller quantity, isn't that right?

17 THE WITNESS: I am just trying to  
18 remember what the concentration of the adult is.

19 THE COMMISSIONER: The adult is  
20 only - the concentration, I have forgotten now,  
21 it is so far away, but it is at least twice the  
22 concentration and it is - I think it is all in all  
23 10 times the --

24 MS. McINTYRE: Four times the  
25 concentration and twice the volume, or is it 10  
times the concentration and twice the volume?







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3 THE COMMISSIONER: I don't know. At  
4 any rate it is a great deal stronger if you use the  
5 adult. I would have thought all the damage is done  
6 by just using the adult, it doesn't really matter  
7 what your concentrations are once you use the  
8 quantity of an adult in place of the infant you have  
9 done the damage, haven't you?

10 THE WITNESS: I find it difficult  
11 to recall right this minute the adult --

12 THE COMMISSIONER: You are not alone,  
13 I find it difficult to recall too, but we can look  
14 it up.

15 MR. ROLAND: I think it was five times  
16 stronger, we are looking it up.

17 THE COMMISSIONER: Five times stronger  
18 and twice the quantity in the ampule, is that it?

19 MS. McINTYRE: So the result is there  
20 is 10 times as much digoxin in the adult --

21 MR. ROLAND: You are correct, twice  
22 the volume.

23 THE COMMISSIONER: Twice the volume  
24 and five times the strength. Even if you just used,  
25 measured out the volume, if you get it five times  
as strong you have done the damage, haven't you?

THE WITNESS: Yes.





1  
2 THE COMMISSIONER: I don't know how  
3 much damage, but it certainly sounds like a lot of  
4 damage to me, five times. So the decimal point, I  
5 am just asking you what the decimal point had to do  
6 with it.

7 MR. ROLAND: Just to make that  
8 absolutely correct, I believe it is five times  
9 stronger in twice the volume, so it actually--  
10 comparing the same volumes, two and a half times  
stronger.

11 THE COMMISSIONER: Two and a half,  
12 is that right?

13 MR. ROLAND: I think that is what  
14 the compendium seems to say.

15 THE COMMISSIONER: Well, perhaps two  
16 and a half times.

17 MS. MCINTYRE: Q. Mrs. Radojewski --

18 A. I am still confused about that,  
19 I am sorry.

20 MS. MCINTYRE: I am sorry, were you  
finished, sir?

21 THE COMMISSIONER: No. Here we are,  
22 we have all sorts of - the Registrar is getting into  
23 the act here and I don't think we need to resolve  
24 that now.  
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MS. McINTYRE: Q. Was your concern the confusion between the two types of ampules, or was your concern about calculations made with respect to the adult ampule?

A. There was concern about both.

Q. Were the --

THE COMMISSIONER: Yes. I am sorry, can I just interrupt now. Obviously - I have got the two now, the Registrar thinks we shouldn't be just guessing at these things, they are right in front of us. The paediatric ampule, there were 10 of them of one millilitre; the adult ampule, five of them of two millilitres. The infant is 0.05 milligrams in one millilitre; and the adult is 0.25 milligrams per millilitre, so it is exactly what Mr. Roland told us, I think it is --

MS. McINTYRE: Absolutely right.

THE COMMISSIONER: The concentration of the adult is five times what it is of the infant, but the volume is two millilitres compared with one millilitre. So I guess I am right in saying - I guess we are all right in saying it is two and a half times as strong.

MR. ROLAND: I am sorry, sir, I thought --





D 1  
2 THE COMMISSIONER: You want to back  
3 off from that?

4 MR. ROLAND: I thought we were right,  
5 I would have to revert to this five times, because  
6 let me read something to you from the compendium of  
7 Pharmaceuticals and it says that --

8 THE COMMISSIONER: I thought you  
9 were referring to one of your assistants as a  
10 compendium.

11 MR. ROLAND: Yes. It says:

12 "Injections, each millilitre contains  
13 digoxin 50 micrograms paediatric, or  
14 250 micrograms --"

15 THE COMMISSIONER: Yes, you are quite  
16 right it is five times, because now that I look at  
17 this again it says 0.25 milligrams per millilitre,  
18 even though it is two millilitres the volume,  
19 obviously there are five milligrams in the two  
20 millilitres.

21 MS. McINTYRE: Q. With that, Mrs.  
22 Radojewski, can I ask you if you have any concern  
23 about --

24 THE COMMISSIONER: I mean 0.5, 0.25,  
25 you are quite right there is some problem with the  
decimal points, but it is five times as strong as







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the other, if we can all agree on that. All I was trying to say was, if you start using something that is five times as strong you don't have to fool around with making errors in decimal points, you have already done the damage; do you agree with that?

THE WITNESS: A point well taken.

MR. YOUNG: I'm sorry, I didn't hear the witness' answer?

MS. McINTYRE: She said point well taken.

THE COMMISSIONER: She is trying to curry favour, she says it was a point well taken.

MR. YOUNG: That is worth repeating.

MS. McINTYRE: Q Mrs. Radojewski, were the adult ampules at some point removed from Ward 4A?

A. They were removed at a later point in time, after March of 1981, before I left The Hospital for Sick Children, we had them removed from our ward stock in that, yes, they would still be available to us but as we needed them.

THE COMMISSIONER: The adults were removed when, did you say?

THE WITNESS: Some time after March 1981 and before I left.





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MS. McINTYRE: Q. So the only ampules then in stock on the ward would be the paediatric ampules?

A. To the best of my recollection, yes.

Q. Mrs. Radojewski, Miss Cronk asked you about some specific medication errors that were made on Ward 4A during this period. Are you aware of any studies that were done at the Hospital with respect to medication errors?

A. Yes. There was one that was done by Jane Gillespie, who was head of the Pharmacy Department at the time she did the study, and that was some time in 1981. I am a little less familiar with the one of Vivien Jenkinson, which was some time in 1978.

MS. McINTYRE: Mr. Commissioner, I would like to introduce those studies as an exhibit.

THE COMMISSIONER: Yes. What is that noise like a steam engine?

MS. McINTYRE: Can I have that marked as an exhibit?

THE COMMISSIONER: Yes, yes. I am sorry, my attention was drawn, there is a steam engine in the next room.





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MS. McINTYRE: Is that right.

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THE COMMISSIONER: I don't know what  
is happening.

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MS. CRONK: Mr. Commissioner, I had  
thought that the Gillespie study had already been  
marked.

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8

THE COMMISSIONER: Has it?

9

10

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MS. CRONK: I know it has been referred  
to by both Ms. Symes and Ms. Kitley in cross-examination  
of other witnesses, at least it was drawn to their  
attention, could we just take a moment to check that?

12

13

14

MS. McINTYRE: I don't think it was,  
I may well be wrong, but we have had these copies  
sitting around our office for a while so I don't  
think it had been marked.

15

16

17

18

MS. CRONK: Well, I don't suggest that  
we delay the matter now, it may well be that the  
witness to whom it was put could not identify it at the  
time.

19

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THE COMMISSIONER: Well, we will mark  
it at the moment as 371, and if it develops that this  
is a duplicate we can just get rid of it.

22

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MS. McINTYRE: The copy that I have  
submitted is, there are certain patient names that  
appear in the original and I have taken the liberty,







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2 Mr. Commissioner, of blanking those out of the copy  
3 that I have submitted.

4 THE COMMISSIONER: That's fine.

5 MS. McINTYRE: It appears in the  
6 Jenkinson report which is appended as an appendices  
7 to the Gillespie report, about half way through, and  
8 it appears on page 2 of the Jenkinson report, you  
9 will notice that there is - the top half of the page  
is blanked out.

10 THE COMMISSIONER: Yes, yes. All right.

11 --- EXHIBIT NO. 371: Medication Administration  
12 System: Department of  
13 Pharmacy, The Hospital for  
Sick Children: B. Jane  
Gillespie, July 28th, 1981.

14 MS. McINTYRE: Q Mrs. Radojewski, do  
15 you have a copy of that report in front of you?

16 A Yes, I do.

17 Q Now the first report, the  
18 Gillespie report, makes reference to the Jenkinson  
19 report which was done earlier in 1978, and could I  
refer you to the earlier report.

20 From the initial summary I take it  
21 that this study was based on 50 patient charts between  
22 the months of January and March of 1978, and the  
23 patient charts were pulled and checked with respect  
24 to accuracy, et cetera, of medications, is that right?  
25





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A. Yes.

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Q. And this report sets out the

4

findings. The first section of selection of the

5

sample which I don't think is important for our

6

purposes; No. 3 is the doctor's orders and there are

7

various items there that had been examined but I

8

don't intend to go into that.

9

But No. 4 is the medication and treatment records, and I take it that that is the sheet

10

that is used by the nursing staff with respect to

11

assigning medications that had been given?

12

A. Yes.

13

Q. And these records were checked,

14

as is set out on page 4, as to whether the drug dosage

15

and routine match the doctor's order; and the chart

16

Table 4, shows that 87 per cent of cases it was

17

correct, and 13 per cent was incorrect, is that right?

18

A. Yes.

19

Q. Secondly, the timing was checked,

20

whether or not the record was up to date, and whether

21

the appropriate spaces were properly signed off and

22

there we find that 60 per cent were correct and 29

23

per cent would be incorrect.

24

25





E  
BM/PS

1  
2 So, I take it that we have some problem  
3 ~~with the~~ nurses might not sign their name at all, is  
4 ~~that correct?~~  
5 A. Yes.  
6 Q. That's what that would show?  
7 A. Yes.  
8 Q. And the next page contains  
9 ~~information~~ of the findings. It is pointed out first  
10 ~~of all~~ the second paragraph that the record, that is  
11 ~~the~~ record is usually kept in the medical  
12 ~~record as a~~ flow chart and although as a nursing record  
13 ~~it is~~ required to be correct for legal purposes.  
14 ~~Are you~~ aware of that?  
15 A. By virtue of reading Vivien's  
16 ~~study I was~~ but I was not previously aware of that.  
17 Q. But apparently the hospital does  
18 ~~keep~~ them in the medical record in any event.  
19 A. Yes.  
20 Q. Now, in the next paragraph I  
21 think we have something that might be of interest  
22 ~~where it says:~~  
23 "We found several wards where drugs  
24 had already been given at various times  
25 that day, but not signed off."  
THE COMMISSIONER: Wait, wait, wait.





1  
2 I haven't found it. Oh, yes.

3 MS. McINTYRE: Q. "Signing the  
4 record was regarded as 'charting' to  
5 be done at the end of the shift, so  
6 no record of whether or not the drug  
7 had been given was available before  
8 3 p.m. or even 7 p.m."

9 I take it that was the practice on 4A, signing at the  
10 end of the shift.

11 A. Yes.

12 Q. "In other wards, nurses are re-  
13 quired to make up check lists of their  
14 peers who have failed to sign these  
15 records, and the check lists are dis-  
16 played prominently at the nurses'  
17 station. Here we found nurses resort  
18 to signing off all drugs before they  
19 have been given, to ensure that their  
20 own names will not appear on the list."

21 I take it that wasn't the practice on your ward.

22 A. Not that I was aware of.

23 Q. But that would apparently show  
24 that it does happen in the hospital in some places.

25 A. Yes.

Q. And on the next page, Mr.







3  
1  
2 Commissioner, the third paragraph on the next page,  
3 it is page 6, it is stated:

4 "Policy for the administration of  
5 digoxin states that two persons are  
6 required. Medication records were ruled  
7 and spaced to allow for double signa-  
8 tures; but only 67% were actually  
9 signed off by two people."

10 Now, that would seem to indicate that two signatures  
11 were required on digoxin and we have heard evidence  
12 previously that that wasn't the practice on 4A, is  
13 that right?

14 A. Yes, that's right.

15 THE COMMISSIONER: They weren't required,  
16 were they?

17 MS. McINTYRE: Weren't required, no.

18 THE COMMISSIONER: No, but this is a  
19 report, apparently they were required at one point  
20 but that ceased, is that right?

21 MS. CRONK: Sir, the evidence to date -  
22 surely that question should be put in a time frame.

23 THE COMMISSIONER: Yes.

24 MS. CRONK: The evidence to date sug-  
25 gests that there did come a time in the latter part of  
March when a double signature was required and as I





1  
2 understand it the time frame covered by these studies  
3 is quite specific and it is after the nine month  
4 period that's in issue.

5 THE COMMISSIONER: Is it after or  
6 before?

7 MS. MCINTYRE: No, this is 1978  
8 in fact.

9 THE COMMISSIONER: This is before, this  
10 is the original one, this is January and March of 1978.

11 MS. CRONK: Oh, all right, I beg your  
12 pardon, I'm sorry.

13 THE COMMISSIONER: In our period, the  
14 period, that is, from 30th of June to the 22nd of  
15 March, was there any requirement for double signatures  
16 on digoxin, because we have never seen that, I have  
17 never seen that.

18 THE WITNESS: I believe the policy  
19 books says that two nurses are required but I don't  
20 know that it says that they are required to sign.

21 THE COMMISSIONER: But there is no place  
22 for it, is there? Can we have any chart at all?  
23 Give me the Miller chart, the Miller record.

24 MS. MCINTYRE: Q. While we are  
25 waiting for that, Mrs. Radojewski, can I ask you if  
you understood that it was double signed elsewhere in





1  
5 2 the hospital?

3 A. It was my understanding it was  
4 double signed on quite a few of the other units because  
5 of their unfamiliarity with digoxin.

6 Q. Where they didn't use digoxin  
7 as much as 4A/B?

8 A. That's right.

9 Q. But on 4A/B there wasn't double  
10 signatures required.

11 A. No, we didn't do - in that  
12 time frame we didn't have double signatures.

13 THE COMMISSIONER: I don't know where  
14 we will find that.

15 MS. McINTYRE: It would be the medica-  
16 tion and treatment record, sir.

17 THE COMMISSIONER: I've got Miller out  
18 here but I never know where we get them.

19 MS. CRONK: Try page 38, sir.

20 THE COMMISSIONER: Oh, here we are,  
21 page 38, I've got one here now.

22 Well, it would be impossible I would  
23 think, if we look at the medication and treatment  
24 record, page 38 for Allana Miller it would be almost  
25 impossible to put two signatures in there.

THE WITNESS: What our practice was,







6      2      was to --

3                                      THE COMMISSIONER: You will have to  
4      speak up.

5                                      THE WITNESS: Oh, I'm sorry. What our  
6      practice was on the medication treatment record  
7      after this period of time is in the time column where  
8      we would write 0900 we would leave another space and  
9      then write 2100. So that the first line adjacent to  
10     0900, the nurse could sign who gave it and then right  
11     below would be the nurse who checked.

12                                      THE COMMISSIONER: But it wasn't done  
13     in this case.

14                                      THE WITNESS: It wasn't done in that  
15     time frame.

16                                      THE COMMISSIONER: No, not in that time  
17     frame, it was before that and after that you said?

18                                      THE WITNESS: After March, 1981 we  
19     then started ruling up so that it would accommodate  
20     two signatures but in that time frame...

21                                      THE COMMISSIONER: Was that just for  
22     digoxin or was that for other drugs as well?

23                                      THE WITNESS: That was just for digoxin.

24                                      THE COMMISSIONER: I see.

25                                      MS. McINTYRE: Q. Do you recall two  
signatures being required at any time on 5A?





Radojewski  
ex. (McIntyre)

1  
2 A. No.

3 Q. So, I take it that prior to  
4 March of 1981, while it may have been required else-  
5 where in the hospital where digoxin wasn't used as  
6 frequently it was not required to have two signatures  
7 on the cardiac ward.

8 A. It was my understanding that the  
9 [redacted] stated that two nurses were required but not  
10 [redacted] signatures.

11 Q. And the conclusions of this  
12 study are set out at page 10 where it states:

13 "In studying the present documents  
14 used to ensure that doctors' medication  
15 orders are carried out, and the correct  
16 drugs given properly to the children in  
17 the wards, we found that the time spent  
18 on transcribing, checking and recording  
19 medications does not result in appropriate  
20 levels of accuracy.

21 We recommend further studies should  
22 be carried out related to

23 (i) the possibilities of using  
24 the doctors' original order as the  
25 basis for dispensing and giving medica-  
tion, without transcription,"





1  
2 at any point during the nine month period were doctors'  
3 orders used for that purpose without transcription on  
4 Wards 4A/B?

5 A. Some time after our clinical  
6 pharmacist started on the ward the doctors' order  
7 form was changed to provide a non-carboned carbon  
8 paper - I'm not sure if that's the right expression -  
9 which was used then to send to pharmacy for dispens-  
10 ing of the medication. However, we did not use the  
11 doctors' order sheet for administering the medica-  
tion.

12 Q. That continued to be done by  
13 transcription of orders?

14 A. By transcription on to a  
15 medication ticket, yes.

16 Q. The second conclusion is:  
17 "(ii) the possibility of using  
18 clinical-based pharmacists to control  
19 and to supervise the local administration  
20 of medications,"

21 and I take it that you did have such a person from  
22 September of 1980 forward?

23 A. Yes.

24 Q. And that was a pilot project on  
25 the 4th floor, as I understand it.





1

2

A. Yes.

3

Q. And the third:

4

"(iii) the possibility of moving

5

towards the Unit Dosage system of medica-

6

tion administration in this hospital."

7

That as I understand it was not implemented until  
after the period in question.

8

A. Yes.

9

Q. Now, the Gillespie report,

10

which was completed July of 1981, refers to the earlier

11

Jenkinson report and the first paragraph indicates:

12

"No significant changes have been made  
since the report was prepared."

13

Then under "Analysis of Medication Errors", it is  
indicated that:

14

15

"Medication errors which occurred in

16

April, May and June of this year have

17

been reviewed. All errors are included

18

in Appendix VI of this report. It is

19

impossible to determine the percentage

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of total errors that are reported. It

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is agreed generally that many errors

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are not detected because the person

23

committing the error is not aware of  
it."

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25







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2 Do you disagree with that statement?

10 3 A. No. There is nursing literature  
4 to support that view in other studies.

5 Q. All right. It then goes on to

6  
7 "The number of reported errors is  
8 extremely small. A minimum of 5,000  
9 doses are administered every day and  
10 in the three months reviewed an average  
11 of 18 errors were reported per month.  
12 This is an unrealistic number."

13 do you disagree with that conclusion?

14 A. I don't disagree with it because  
15 of Miss Gillespie's knowledge, but it is my impression  
16 if you don't know that you are making an error you  
17 can't report it.

18 Q. I take it as head nurse you would  
19 have no way of knowing how many undetected or unreported  
20 errors occurred on 4A?

21 A. I don't know how I could know  
22 that.

23 THE COMMISSIONER: I don't know, but  
24 sometimes -- I am trying to understand the sentence  
25 before:

"The reporting routine at the hospital





11 2 is not punitive but rather a documenta-  
3 tion process..."

4 Just pausing there, does that mean that there is no  
5 punishment ever meted out for an error. Is that what  
6 that says, is that what it means? What really gets me

7 "...so it is assumed that most if not  
8 all detected errors are reported."

9 Now, it is assumed by whom, I wonder, is it assumed  
10 by the author of this because if it is it seems to  
11 be contrary to what she says in the next sentence. But  
12 if it is assumed by the hospital then perhaps it is...

13 MS. MCINTYRE: Well, it says:

14 "The number of reported errors is  
15 extremely small."

16 And it concludes:

17 "This is an unrealistic number."

18 THE COMMISSIONER: Yes, but what it  
19 says is:

20 "...so it is assumed that most if not  
21 all detected errors are reported."

22 That means by that I take it that no one who knows  
23 of an error will keep it quiet, is that what that  
24 means?

25 MS. MCINTYRE: Well, the way I read it,





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sir, and perhaps we should have the author herself here to explain what she was thinking --

THE COMMISSIONER: No, no.

MS. McINTYRE: -- but the way I read it is that because there is a reporting routine which is not punitive, one would assume that ---

THE COMMISSIONER: That everybody will own up.

MS. McINTYRE: But that maybe is not a correct assumption in that the number that are actually reported is unrealistically low. So, perhaps that theory of a non-punitive reporting system is not one that ensures actual reporting.

THE COMMISSIONER: Well, it is possible that what she means is that it may be the 'it' that is assumed by her, that she is meaning that the detected errors are practically all reported but there are an enormous number of undetected errors that are not reported, is that right?

MS. McINTYRE: Well, the way I read it is that while she states that as a general assumption that one would assume that would be the case that the statistics don't bear out that assumption, but it is hard for us to read her mind just looking at this report.







1  
13 2 THE COMMISSIONER: I hope a certain  
3 report that might come out of this that that won't  
4 be that difficult.

5 MS. MCINTYRE: I'm sure it won't,

6  
7 THE COMMISSIONER: Well, it's hard to

8 MS. MCINTYRE: Q. She then goes on  
9 to indicate that:

10 "There is a high incidence of errors  
11 involving intravenous solutions,..."  
12 and refers to a specific example.

13 And on the next page:

14 "One reason for this problem may be  
15 the unusually heavy requirement for  
16 nursing staff in the hospital to prepare  
17 and/or mix I.V. solutions because of  
the special needs of pediatric patients."

18 Do you agree with that?

19 A. Yes.

20 Q. "This is properly a pharmacist's  
21 responsibility and should be managed by  
22 a pharmacist on the nursing unit.  
23 There are several errors in which the  
24 wrong drug was given, for example,  
25





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furosemide instead of hydralazine."

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Can you tell us what those drugs are, please.

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On the fourth page of the report she suggests that:

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I take it that brings us back to our earlier discussion.

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that on?

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MS. MCINTYRE: This is the top of the page with the little picture on it.

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THE COMMISSIONER: Yes, all right.





/EMT/ko

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2 MS. MCINTYRE: Q. Now, glancing  
3 briefly at the medication errors that have been  
4 reported which appear at the very back of this  
5 document, I take it that this includes the whole  
6 range of types of error, including wrong drug, wrong  
7 time, wrong dose and even wrong patient?

8 A. Included not given as well.

9 Q. Yes. Omission. In your  
10 experience is that the range of errors that occurred  
11 in the giving of medications?

12 A. I am not sure I understand your  
13 question.

14 Q. Are you familiar with those  
15 different types of errors, wrong drug, wrong dose,  
16 et cetera?

17 A. Yes.

18 Q. Mrs. Radojewski, with respect to  
19 Baby Bilodeau you told Ms. Cronk you felt he should  
20 have had an electrocardiogram done at the time of his  
21 admission which was on the Saturday, July 19th, when  
22 in fact it was not done until Monday, July 21st, which  
23 was the day prior to the night of the child's arrest.

24 Why did you feel that the echocardiogram  
25 should have been done earlier?

A. I feel that the echocardiogram





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would have given us a more definite idea of his diagnosis and severity of it, and we may have been able to institute some other treatment much sooner.

Q. Do you recall if your nursing staff were concerned about the way in which this child was managed?

A. The nursing staff concerns after Baby Bilodeau had arrested centred around the support for the family and I believe the fact that the diagnosis wasn't known sooner and this could have been conveyed to the family that the child may run into more trouble. It was just a lack of good communication between physicians, the parents and the nurses.

Q. Would knowing the diagnosis sooner have facilitated the care of this child in any way?

A. We may have been able to provide him with some kind of other support, such as ventilation, but it is difficult to answer your question because I know that in retrospect we were told at the meeting that his type of truncus arteriosus was relatively inoperable.

Q. I take it that the delay in doing the echocardiogram was something that was raised at







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the September 5th meeting?

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A. Yes, it was.

4

Q. As you have reported, or  
recorded in your notes which are Exhibit 46 - I would  
like to refer you to those notes. Do you have a copy  
of them there?

7

A. Yes.

8

THE COMMISSIONER: What is that?

9

MS. MCINTYRE: This is Exhibit 46.

10

11

Q. On the second page of this note  
the question raised, "Would ICU earlier have  
made a difference?".

12

13

Did you have an opinion on that at the  
time as to whether this child would have benefitted  
from ICU?

14

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A. In retrospect certainly after  
learning the child had died I remember feeling that  
he should have gone to Intensive Care.

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19

Q. What would Intensive Care have  
offered this child that was not available on Ward 4A?

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A. Closer monitoring and the  
availability of being put on a ventilator.

22

Q. That is for respiratory distress,  
is it?

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A. Yes.





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Q. What does that involve? What is it that the ICU offers in that regard?

A. The ICU has the availability of an anaesthetist or doctors who are trained at putting in endotracheal tubes in patients that they then can be put on ventilators.

Q. Does it require an anaesthetist to put a child on a ventilator?

A. Yes.

Q. At the beginning of the notes of that meeting, Exhibit 46, there is certain preliminary information set out.

Do you recall where it states that there are about a hundred deaths per year what that reference was to?

A. I don't recall then but now it refers to the number of cardiac deaths we see in a year. Not exclusive to the ward.

Q. At the pathology conferences referred to, were those ones to which the nurses were invited?

A. No, we were not.

Q. There is a comment made, "Try to keep the meetings on the ward going. Try for lunch to draw more people."





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1  
2 I take it that was an indication of  
3 continuing these meetings on the ward with the nurses?

4 A. It was felt that these meetings  
5 would provide a means of ongoing education for the  
6 nursing staff.

7 Q. And I take it from the next  
8 comments that information on post mortems was going to  
be given to nurses at these meetings?

9 A. Yes.

10 THE COMMISSIONER: Is this a good time?

11 MS. MCINTYRE: Yes, please.

12 THE COMMISSIONER: All right. We will  
13 take 20 minutes.

14 ~~--- Short recess~~

15 ~~--- On resuming~~

16 THE COMMISSIONER: Yes, Ms. McIntyre?

17 MS. MCINTYRE: Thank you, sir.

18 Sir, Mrs. Radojewski informed me that  
19 she was re-thinking her agreement with you on the dig.  
20 and she has decided that there was another point that  
she wanted to make on that.

21 THE COMMISSIONER: Oh, yes, certainly.  
By all means.

22 THE WITNESS: A nurse - I didn't want  
23 to leave you with the impression that an adult ampule  
24  
25







1  
2 could not be used for a pediatric dose because it can  
3 be. If you are - in calculating the dose that the  
4 doctor has ordered, if you can administer that dose  
5 in a smaller volume, you can then use the adult ampule  
6 to calculate the dose.

7 THE COMMISSIONER: Were they normally  
8 used? The prescription of digoxin, 0.032. Could I  
9 see those things again? And could we have out the  
10 Allana Miller medical record for Mrs. Radojewski too,  
11 please?

12 0.032. Now what you are saying - could  
13 you turn to page 38 on Allana Miller's chart and you  
14 will see the last entry is 0.03. Is that 0.03 or is  
15 it 0.032?

16 THE WITNESS: That is 0.032.

17 THE COMMISSIONER: And that is milli-  
18 grams, is it?

19 THE WITNESS: Yes.

20 THE COMMISSIONER: And as prescribed.  
21 Now what you say is you could use, first of all, the  
22 pediatric lanoxin or digoxin as it is?

23 THE WITNESS: Yes.

24 THE COMMISSIONER: And you would  
25 realize I take it that 0.03 is a certain --

THE WITNESS: It would be approximately





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.6 of a millilitre of that preparation.

THE COMMISSIONER: You say you can calculate it from either the adult or the --

THE WITNESS: Or the pediatric, yes.

THE COMMISSIONER: Is it a matter of indifference which one is used?

THE WITNESS: If you are working with very small doses, and 0.032 is --

THE COMMISSIONER: Is a very small dose.

THE WITNESS: -- is a small dose, you would use the pediatric preparation.

THE COMMISSIONER: Yes.

THE WITNESS: If you are working with a much larger dose you would use the adult preparation.

THE COMMISSIONER: Yes.

THE WITNESS: I was just afraid that you might think we never use the adult one.

THE COMMISSIONER: No, really what I had in mind was if you mistook the pediatric for the adult, all the damage was done because calculations then would make no sense at all because you would think you were working on a concentration such as is in the pediatric, whereas in fact you are getting a concentration which is five times as great in the





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adult one. But you can use the adult one is the point you are making so long as you know you are using an adult one and you calculate accordingly?

THE WITNESS: Yes.

THE COMMISSIONER: Yes. All right.

MS. MCINTYRE: Q. I take it that the concern was because the calculations were different, there is more possibility for confusion when you got the two different types of ampules available?

A. Yes.

Q. Okay. Phillip Turner, Mrs.

Radojewski, was also discussed at the September 5 meeting, and you told Ms. Cronk you had concerns about this child being on the ward as opposed to the Intensive Care Unit.

Can you explain why?

A. I had had some prior knowledge of Phillip Turner's post-operative course in the Intensive Care and he had suffered left lung collapse I believe at least once, and with that history it was my feeling that he had come up to the ward too soon; that his overall chest condition was not optimum.

Q. So again you thought he would benefit from ventilatory support that you were referring to earlier?





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A. I thought he would benefit from having the availability of that ventilatory support being there as quickly as he might need it.

Q. I take it from the tour end report - you have those there? Exhibit 360, Mr. Registrar.

The back of page 18. This is your writing, is it not?

A. For the day period, yes.

Q. That that was considered during the day shift. It says "should go to the ICU".

A. Yes.

Q. Then it says "cardiologist assessing".

What does that mean?

A. Nurses cannot transfer patients to Intensive Care without a doctor's order, and the doctor has to assess the patient, review the patient's condition and see whether they meet the criteria for going to Intensive Care.

Q. Where it states "should go to the ICU", do you recall if that was your opinion or was that an opinion that a physician had made?

A. I can't accurately recall that it was my decision.







1  
2 Q. But I take it in any event the  
3 child did not go to the ICU?

4 A. No, he did not.

5 Q. And arrested on the ward?

6 A. Yes.

7 Q. You said that you would not be  
8 able to make that decision as a nurse. It would  
9 require a doctor's order to transfer a patient to  
10 ICU?

11 A. Yes.

12 THE COMMISSIONER: Doing a little  
13 thinking out loud, Ms. McIntyre, is this leading to  
14 the cause of death?

15 MS. McINTYRE: Well, Mr. Commissioner,  
16 I think that these were concerns that were raised at  
17 the time.

18 THE COMMISSIONER: That is right.

19 MS. McINTYRE: By the physicians  
20 involved.

21 THE COMMISSIONER: I understand that.  
22 I understand that, and there apparently might have  
23 been a difference of opinion that the nurses thought  
24 that the child should go to the ICU and the doctors  
25 thought not. But you see we can get into a terrible  
dispute as to whether it was proper for the child to  
go to the ICU or not.





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2 But unless it caused- you see, what I am asked to  
3 do is how and by what means the children met their  
4 deaths, and unless there is an allegation that there  
5 is medical negligence, and I am talking about  
6 medical, about doctors' negligence, we shouldn't  
7 be going into this at all.

8 Ms. Cronk I noticed asked about  
9 nursing care from time to time, and you have asked  
10 about nursing care, did that in any way affect the  
11 care and progress of the child. If it didn't, I  
12 want to forget about it, I want to ignore it. If  
13 it did, maybe I have to go into it, that's all.

14 MS. MCINTYRE: Well, Mr. Commissioner,  
15 I think that, yes, it should be gone into, because  
16 at the time it was raised at the September 5th  
17 meeting the possibility with both these children  
18 that they should have gone to the ICU. I had  
19 understood that you were examining any possible  
20 contribution to the cause of death.

21 THE COMMISSIONER: Well --

22 MS. MCINTYRE: And this may well be  
23 a contributing factor. In fact, in the January  
24 12th meeting, it was decided by the group that that  
25 was a contributing factor in a number of the deaths,  
and therefore I would submit --





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THE COMMISSIONER: I really don't want  
I can tell you I certainly don't want to go into it  
because it just means, it means a dispute between  
the doctors and the nurses. Whereas really the major  
issue here surely is the digoxin, is it not?  
Isn't that the real problem that we are faced with?

MS. MCINTYRE: Well, Mr. Commissioner,  
I know that the evidence has been focused on digoxin,  
but I still think that there exists a possibility of  
other causes of death. Like in a number of these  
children --

THE COMMISSIONER: Well,  
the other cause of death I would make it all in  
~~one great~~ blanket as natural, it is a natural death.  
You see, you can't have absolutely perfect care, for  
anybody, because the good Lord hasn't given us the  
mentality to do that. But we can determine if someone  
is intervening, or if some accident, if you like,  
some mistake, or some deliberate act has resulted  
in the death of a child, or has contributed largely  
to the death of the child. But where it is just  
a question of perhaps it would have been a good idea  
to send him to the ICU, or perhaps it wouldn't have  
been a good idea to send him to the ICU, do you  
think that comes within my mandate, that I have to go





1  
2 over it? You see, I am not a doctor, I can't really  
3 decide those kinds of issues as to whether the child  
4 should have gone to the ICU, or whether they shouldn't.  
5 I might have about 20 doctors coming in saying, no,  
6 in our considered opinion he was better off where  
7 he was. I am left with the opinion of the doctors  
8 and the opinion of the nurses, and it really doesn't  
9 help me much on the cause of death.

10 The real question is, did somehow or  
11 other this child get an overdose of digoxin? It seems  
12 to me I have made this speech several times.

13 MS. McINTYRE: Yes, to me, sir, I think.

14 THE COMMISSIONER: Well, I think I have  
15 made it to several people, I don't think I have been  
16 especially favoring you.

17 MS. McINTYRE: Well, with respect, sir,  
18 I see your mandate has been broader than deciding  
19 merely whether or not these children, or some of them  
20 received -- died from an overdose of digoxin, deliberate  
21 or otherwise.

22 THE COMMISSIONER: Well, if there is  
23 any strong evidence of any other unnatural cause I  
24 can well see that that is part of my mandate. But  
25 is it my mandate, really, to consider whether some  
doctor made a mistake, or didn't make a mistake in the







1  
2 course of the treatment of the child; or perhaps  
3 some nurse made a mistake.

4 MS. McINTYRE: Well, sir, in January  
5 of 1981 there was a meeting amongst the top physicians.

6 THE COMMISSIONER: Yes.

7 MS. McINTYRE: And the top representa-  
8 tives of the nursing department in the hospital, at  
9 which they examined the deaths that had occurred.  
10 They came up with a number of factors which they felt  
11 contributed to those deaths, and whether or not  
12 that indicates that the children didn't get the care  
13 they should, I am not going to express an opinion on  
14 it, and I think your mandate requires you to --

15 THE COMMISSIONER: That is the only  
16 conclusion I can draw from what you are asking me, is  
17 to ask me to draw the conclusion that the children did  
18 not get the care that they should have, because this  
19 child, you claim, should have been in the ICU earlier.  
20 That is the purpose, I take it, of this line of  
21 questioning. The fact that he was not in the ICU  
22 earlier contributed to his death, but his death too  
23 is natural, if that is so, it was not an unnatural  
24 death.

25 MS. McINTYRE: That may well be so,  
but if it is a factor that it is at all contributing to





4      1  
2      2 the cause of death, sir, I think he should be looking  
3      3 at it.

4      4 THE COMMISSIONER: You are turning me  
5      5 into a doctor, what is the cause of death? I would  
6      6 have to go into everything, perhaps somebody sneezed  
7      7 in the room that particular day. There is a limit  
8      8 to what I can do, and I can't do that sort of thing.  
9      9 I am not going to stop you from this, but I am going  
10     10 to tell you that it really doesn't fascinate me, this  
11     11 problem of the care of the children there. Mind you,  
12     12 if it were an outrageous performance, if somebody  
13     13 left the window wide open and the child died of  
14     14 pneumonia, I suppose I could make some comment with  
15     15 respect to the fact, but that is not the impression  
16     16 that I have got so far. If it is any consolation to  
17     17 you, I got the impression that the care was excellent.  
18     18 I really would like to be able to say something in  
19     19 the Report that the care was excellent for these  
20     20 children. But you are going to force me into a  
21     21 corner where I am going to say that  
22     22 it has been argued that these children  
23     23 were not put in the ICU, they should have been in;  
24     24 perhaps something else was done to them by the doctors  
25     25 that should not have been done to them. I really  
don't want to be put in that position because I don't  
think that is basically what I am asked to do. I am





1  
2 asked to say; did they die naturally or did they not,  
3 that in effect is what I think I am being asked.

4 Now, I know Mr. Labow does not agree with me and he  
5 is over there, and I have known that from his cross-  
6 examination from way back when, Mr. Labow, but I am now  
7 baring my soul.

8 MR. LABOW: Mr. Commissioner, in the  
9 Terms of Reference where it says, with the greatest of  
10 respect:

11 "Whereas, the Government of  
12 Ontario is of the view that there is  
13 a need for the parents of the deceased  
14 children and the public as a whole to be  
15 informed of all available evidence as  
16 to the deaths..."

17 doesn't restrict you to questions concerning digoxin  
18 only.

19 THE COMMISSIONER: Can't we practical  
20 about this thing, what is the Commission really about?  
21 This Commission is whether or not these children  
22 died naturally, surely that is the issue that is  
23 before us. It is not about -- I have allowed all  
24 this evidence and I am going to I know be beaten into  
25 a corner and I will receive it all again, but at  
least I should tell you my thinking at the moment





1  
2 so that you will know that that is the issue. If I  
3 don't keep the main issue in front of me all the  
4 time I will never be able to handle this Commission.  
5 Yes, Ms. Foster, you are going to say I will never be  
6 able to anyway.

7 MS. FOSTER: No, I am not, sir. It  
8 seems to me that with the exception of the children  
9 for whom there is toxicological data --

10 THE COMMISSIONER: Yes.

11 MS. FOSTER: The only evidence we  
12 have as to digoxin causing death of these other  
13 children, is some evidence that says their  
14 death was sudden and unexpected and the terminal  
15 events were consistent with digoxin.

16 THE COMMISSIONER: Yes, that's right.

17 MS. FOSTER: To the extent that this  
18 witness may say, or anybody who had hands on care  
19 of these children, may say, I had concerns many days prior  
20 to the death about the condition of the child,  
21 I think this evidence may be relevant, not in terms  
22 of the actual care or the negligence -- I am not  
23 saying that.

24 THE COMMISSIONER: I agree with you  
25 it may be relevant but it will only be relevant if  
it has a major effect upon the deaths of the children







Radojewski  
ex. (McIntyre)

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1  
2 and I think that can only be if there is some major  
3 error that has been made by somebody.

4                   However, as I say, I will be beaten  
5 into a corner and I will allow the evidence, but when  
6 you are asking it, would you please at least somewhere  
7 say; do you think that that affected - it contributed  
8 to the death of the child, you can at least ask that  
9 question. Because if it didn't, if in the opinion  
10 of the witness it had nothing to do with the death of  
11 the child, then surely I don't want to hear it.

12                   MS. MCINTYRE: Okay, Mr. Commissioner,  
13 I will ask that question. I would just like to make  
14 two other comments with respect to what you have  
15 said.

16                   First of all, you suggested that there  
17 might be some difference of opinion between the nurses  
18 and the doctors put forward as to whether the children  
19 should go to ICU. I am not suggesting that is  
20 the case. In fact, I think in these examples both  
21 the doctors and nurses felt that there were a number  
22 of these children who would have benefited from  
23 more intensive care.

24                   Another point is I think this evidence  
25 is relevant to this witness' state of mind, as  
to why she did not perceive there being anything





1  
2 unforeseen going on. It has been put to her that  
3 surely she must have thought that this was more than  
4 just a coincidence.

5 THE COMMISSIONER: I think for the 75th  
6 time in this Commission I will say it would have been  
7 better if I had said nothing and just carried on with  
8 the evidence, we would have saved time.

9 MS. MCINTYRE: I'm sorry, Mr. Commissioner.

10 Q. Mrs. Radojewski, did you at any  
11 time, or do you now think that the fact that Philip  
12 Turner was not put into ICU earlier in any way  
13 affected his chances of survival?

14 A. I don't know that I feel really  
15 qualified to answer that, I find it difficult to make  
16 that kind of opinion.

17 Q. Did you at any time feel that  
18 any of the physicians felt that him being in the  
19 ICU would have either extended his life span, or  
20 prevented his having an arrest?

21 A. I don't recall that being raised  
22 as such. The impression I am left with is that we  
23 could have had that to offer him, and it might have  
24 made a difference, and it might not have, I can't be  
25 any more definite than that.

Q. Was it your impression that





1  
2 it was the opinion of the physicians at the end of  
3 the September 5th meeting that an intermediate intensive  
4 care unit would be relevant to the problem of the deaths  
5 on the ward?

6 A. Could you repeat that for me,  
7 please?

8 Q. At the end of the September 5th  
9 meeting did you -- were you of the opinion that the  
10 doctors thought that an intensive care unit would  
11 alleviate the deaths that you were having on the  
12 ward, or was a response in any way to those  
13 deaths?

14 A. It was a response, it was in an  
15 effort to try and do more for these patients to offer  
16 them more.

17 Q. Was that -- did you have the  
18 impression that they thought that would affect the  
19 life span of some of the children on the ward?

20 A. It was just -- at the September  
21 5th meeting it was the suggestion, I don't remember  
22 giving it a lot of serious thought in September, be-  
23 cause I didn't feel that we could offer an ICU  
24 setting, there was no criteria at that time for the  
25 term, "an intermediate ICU setting".

Q. At the end of the September





1  
2 meetings; did you feel that any of the deaths that  
3 had been discussed were unexplained?

4 A. No, I accepted the explanations.

5 Q. To move on to another topic;  
6 Ms. Cronk asked you about a discussion you had had  
7 with each of Susan Nelles and Phyllis Trayner about  
8 a difference of opinion that was held. She didn't  
9 ask you what the outcome of that discussion or those  
10 discussions was. Can you tell us what the outcome  
11 was?

12 A. After I had had the discussions  
13 with both Mrs. Trayner and Ms. Nelles I left them to  
14 think about it for a few days, to resolve their  
15 differences. When I returned to work the next time that  
16 I saw them they informed me that they had had a long  
17 talk, talked this out, and felt they could get along  
18 much better together.

19 Q. Do you recall when that was,  
20 approximately?

21 A. At this moment I can't recall.

22 Q. Was any followup on your part  
23 necessary?

24 A. No, it was my impression that  
25 they were working well together and I was not  
made aware of any further problems.







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Q. Did you from time to time know  
of conflicts between other team members on 4A?

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A. I learned of - conflicts is such a strong word. I learned of some unhappy feelings that some of the team members had with their team leaders.

Q. And did you feel that the Trayner team had any more unhappiness or differences than the other teams on the unit?

A. Except for that one incident I don't feel that their differences or unhappiness was unique to that team, no.

Q. You indicated that you didn't seriously consider splitting up the Trayner team, is that right?

A. Yes.

Q. For what reason would you consider splitting up a team?

A. If there were several occasions if I can rephrase that. If there were occasions when a team just didn't get along and it was detrimental to patient care, then I would consider splitting up the team or perhaps even removing some members.

Q. Do I take it that you had not reached that conclusion with respect to the Trayner team?

A. That's right.





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Q Did you at any time in the  
nine-month period up until the death of Justin Cook  
consider that the deaths on 4A were attributable  
to the incompetence of the Trayner team or any of  
its members?

7

A No, I did not.

8

9

Q If you thought that that was  
causing the deaths on the ward, what would you have  
done about it?

10

11

A I would have removed them and  
investigated the matter further with my superiors.

12

Q Removed them from the ward?

13

A Yes.

14

15

16

Q Did you, during that period of  
time, ever consider that the deaths on the ward were  
attributable to any deliberate act of the team or  
any of its members?

17

A No, I did not.

18

19

Q If you had considered that,  
what would you have done?

20

21

A If there was a deliberate act  
by any of the nurses I would have removed them and  
again investigated it with my supervisors.

22

23

24

25

Q Would the splitting up of the  
team have been an appropriate solution if that were  
the problem?





H. J.

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3 A. If that were the problem, the  
4 splitting up, I doubt if it would have made any  
5 difference.

6  
7 Q. So, I take it that from your  
8 evidence that you attributed the fact that a lot of  
9 the deaths were occurring with that one nursing team  
10 to be bad luck or a jinx?

11 A. Yes.

12 Q. Is that the first time in your  
13 nursing career that you have heard of such a thing,  
14 one team being jinxed?

15 A. I'm having trouble with the  
16 term one team.

17 Q. Or one nurse?

18 A. Thank you. The team system, as  
19 it was then, was a very new phenomenon but in my  
20 experience it has been known that there are nurses  
21 who have arrests on their shift and there are nurses  
22 who can go through the majority of their whole career  
23 and not meet up with arrests or death.

24 Q. I take it that the staff  
25 members on the team rotated through shifts while you  
continued to work day shift?

A. Yes.

Q. How frequently would you have







H.4

1  
2 the opportunity to work directly with a particular  
3 team?

4 A. It was actually very infrequently,  
5 it was five days in four weeks.

6 THE COMMISSIONER: Did you arrange  
7 your rotation so that you would get every team  
8 occasionally?

9 THE WITNESS: I worked with every team  
10 member five days out of four weeks.

11 THE COMMISSIONER: I mean, that always  
12 happened, the way you sorted it out?

13 THE WITNESS: Yes.

14 MS. MCINTYRE: Q. And I take it that  
15 you would not always be on the ward during the shifts  
16 that you were there, that you had other administrative  
17 duties that would take you away from the ward, is that  
18 right?

19 A. Yes.

20 Q. Can you give us any idea  
21 approximately what portion of your time would be taken  
22 by those duties?

23 A. The duties away from the ward,  
24 and I am including some of those which I had to do  
25 in the privacy of my office which was down the hall  
from the ward, would be about 50 per cent.





2 Q And while you were away from  
3 the ward, to whom did you delegate patient care?

4 A While I was away from the  
5 ward and even while I was on the ward there was a  
6 lot of responsibility delegated to the team leader  
7 for direct supervision of patient care.

8 Q Ms. Cronk asked you with respect  
9 to a number of children questions about the coroner.  
10 As a nurse, would you ever be involved in calling  
11 the coroner?

12 A I never have been and it is  
13 my assumption that that is a responsibility of the  
14 physician.

15 Q With respect to any of the 36  
16 deaths that we are discussing here, did you feel that  
17 other than at those cases where a physician called  
18 the coroner that it was appropriate to do so?

19 A No, I didn't feel that it was.

20 Q There were a number of deaths  
21 on 4A/B in December of 1980. Ms. Cronk asked you if  
22 at that time you had cast around for an explanation  
23 for the deaths. Did it occur to you at any point up  
24 until that time that there might be one single reason  
25 for the deaths on the floor?

A No, each child's anomaly was





1  
2 unique and their deaths were explainable by virtue  
3 of the complex anatomy many of them had.

4 Q I think January you attended  
5 the meeting with the physicians and other represen-  
6 tatives of the Nursing Department, is that right?

7 A Yes.

8 Q At which the deaths up to that  
9 time were reviewed?

10 A Yes.

11 Q And a number of factors were  
12 discussed which were thought to be perhaps contributing  
13 causes to those deaths?

14 A Yes.

15 Q Did you disagree with the  
16 conclusions that were reached at that meeting?

17 A I don't remember disagreeing  
18 with the conclusions. My best recollection is the  
19 thrust that was put forward for the intermediate ICU.

20 Q At the end of that meeting  
21 did you feel that the deaths which had occurred on the  
22 ward were unexplained?

23 A No.

24 Q Did you feel that the factors  
25 that were raised at the meeting were contributing  
causes to the deaths, and perhaps I should go through





1  
2 them. I'm referring to Exhibit 65, which are the  
3 minutes to that meeting. In what is headed:

4 "2. Discussions from the Medical  
5 and Nursing Staff:

6 "Dr. Edmonds addressed the problem  
7 of transfer of patients from the ICU  
8 to the ward ...

9 "He pointed out that the census in  
10 the ICU is higher now than it has  
11 ever been, the nursing resources are  
12 very stretched and there are obviously  
13 occasions today when patients who  
14 are discharged from the ICU are not  
15 ready for ordinary nursing care."

16 Is that an observation that you yourself  
17 had made?

18 A Yes.

19 Q Did you feel that that was in  
20 any way a contributing factor to the deaths that had  
21 occurred on the ward?

22 A It was something to be considered.  
23 I still find it difficult to give a definite opinion  
24 but it was definitely that should have been taken  
25 into consideration.

Q Did you feel that the physicians







at that meeting were under that impression?

A. Yes, I did.

Q. The next paragraph makes reference to Dr. Trusler's comments about availability of space in the operating room. Did you have any direct knowledge or problem in that area?

A. I was aware of the backlog at times in the operating room but not as aware as I was of the ICU issue.

Q. Did you yourself feel that that may have been a contributing factor to the deaths that were occurring on the ward?

A. As it was raised by the physicians I was in agreement with them.

Q. Next:

"Dr. Rowe and Dr. Fowler addressed the need to change some medical-surgical policies over the need to re-operate."

and that is at an earlier stage in the child's condition. Did you have any direct knowledge of a problem in that area?

A. I'm having difficulty with the question. In this time frame?

Q. Yes, as of January of 1981.





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2  
3 A It is difficult to recall that  
4 independently because although I have no independent  
5 recollection of Baby Lombardo, in reviewing the chart,  
6 when an infant comes up with a heparin infusion to  
7 keep a shunt open, a nurse or any of the physicians,  
8 it must have crossed their mind how long can you keep  
9 someone on heparin infusion to keep the shunt open,  
10 what is our long-term goal for this child and in that  
11 respect, yes, I would have to agree.

12 Q Might the Lombardo case be one  
13 where a re-operation sooner may have been a factor  
14 with respect to his death - her death, sorry?

15 A It may have been.

16 THE COMMISSIONER: We don't know in  
17 Lombardo, do we, whether the shunt was operative or  
18 not?

19 MS. McINTYRE: No.

20 Q On page 3, Mrs. Radojewski,  
21 there is a reference to resident coverage being rather  
22 thin. Was that consistent with observations that you  
23 yourself had made?

24 A That was a period of time when  
25 the residents seemed to be extremely busy and I  
remember that very often they were late doing their  
orders, seeing the ICU transfers and the admissions.





1  
2 They also had a varied experience, a varied background  
3 in paediatric cardiology.

4 Q Did you consider that that in  
5 any way explained the increased death rate on the  
6 ward?

7 A Again, it was a factor to be  
8 considered. I can't be any more definite than that.

9 Q And then there was discussion  
10 about the intermediate ICU, which I take it you  
11 participated in a subcommittee on, is that right?

12 A Yes.  
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Q. I notice that other representatives of the nursing department at that meeting were Miss Geiger, yourself, Miss Costello and Miss Pyykkonen.

A. Yes.

Q. Did you get any feedback from either Miss Geiger or Miss Pyykkonen about following on this meeting?

A. Mrs.Pyykkonen had relayed to me at some point after this not to worry or get too involved in the organizing of this until it was passed by Administration and there was budget approval.

Q. That is the Intermediate ICU?

A. Yes.

Q. Following the meeting in January did you have any further meetings, formal meetings with physicians about particular deaths on the ward or about the increased death rate generally?

A. I don't recall that I did.

Q. What about with people from nursing office, Miss Geiger or Miss Pyykkonen?

A. I don't recall that I did.

Q. Upon leaving that meeting in January did you think that the factors mentioned plus the individual condition of the children adequately explained their deaths?







1

2

A. Yes.

3

Q. Exhibit 368, of which we now

4

have the original...

5

Mr. Registrar, if you would please  
give the original of that exhibit to the witness.

7

These are the notes that you made at  
the time you had discussions with team leaders from  
4A and 4B?

9

A. Yes.

10

Q. I know there was discussion

11

on this yesterday. Are you at this point sure whether  
or not one of those team leaders was Phyllis Trayner?

12

13

A. I was uneasy with my recol-  
lection yesterday because of the prior day when I  
was sure that I had spoken with Phyllis Trayner and  
learned through the WIN sheet that she wasn't on duty.

14

15

16

Q. You mean on the Velasquez

17

incident?

18

A. Yes.

19

Q. So I take it you are not sure  
but you think she may have been?

20

A. Yes.

21

Q. Is that fair?

22

A. Yes, that's fair.

23

Q. Can you tell us what the

24

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focus of them coming to you was?

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A. Their focus was raising some of the concerns that they had about the cardiology Fellows that were left to cover the ward on shift.

6

7

Q. Did you consider the problem to be a serious one?

8

9

A. Serious enough because they came with the concerns and I took them to Dr. Fowler as soon as I could find him.

10

11

12

Q. Did you think that the concerns they were raising were ones that might affect patient care on the unit?

13

14

A. That is a possibility, yes.

15

16

17

Q. Why did you go to see Dr. Fowler? Why would he be the one to see?

18

19

20

A. Dr. Fowler was in charge of the clinical aspects of Cardiology, and he was in charge of the Fellows and the Residents.

21

22

23

24

25

Q. Who would you normally communicate to with respect -- or what was the normal line of communication between yourself and the physicians?

A. If we had issues to raise about the patients, such as elevated temperatures or those sorts of things, we went to the Pediatric





1  
2 Residents on the ward. If there were concerns that  
3 I felt the Pediatric Residents couldn't satisfy me  
4 with - in other words I didn't feel confident about  
5 their knowledge of Pediatric Cardiology - I may then  
6 go to the Fellow and then again to the physician in

7  
8 Q. So in this case you felt  
9 it appropriate to go to Dr. Fowler I take it?

10 A. Dr. Fowler was the head of  
11 the clinical aspect of Cardiology at the Hospital.

12 Q. Ms. Cronk asked you a number  
13 of questions about Floryn and the issue raised as to  
14 what medications this child had received. Was it  
15 your impression at the time that there was any real  
16 problem with respect to the medications he had  
17 received?

18 A. It was my impression that they  
19 were more concerned about the doctor's attitude than  
20 actual medication.

21 Q. You said you didn't follow up  
22 on the medications that had been prescribed. Can  
23 you explain why not?

24 A. I didn't feel that that was  
25 the issue; that Dr. Su's behaviour in that situation  
with Bruce Floryn was more the issue.





15 1  
2  
3 Q. I take it that the problems  
or criticisms are summarized on page 3 of 368?

4 A. Yes.

5 Q. And looking at the original  
6 can you tell us if Dr. Fowler made any responses to  
the criticisms that you did raise?

7 A. In No. 3, when I asked him  
8 about the authority to stop resuscitation, he then  
9 had said to me it was the staff cardiologist's  
10 decision.

11 Q. And what was his general  
12 response to the criticisms you had raised with him?

13 A. The general response, the  
14 impression he left me with, was this was how it was  
15 and there really wasn't any way to change it, and he  
16 asked me, because I was so concerned, if I wanted  
a cardiologist to sleep on the ward overnight.

17 Q. What did you indicate?

18 A. I told him we could make him  
19 very comfortable.

20 Q. I take it that the cardiologists  
21 didn't start sleeping on the ward overnight after that?

22 A. No, they didn't.

23 Q. Was that a serious suggestion  
24 on his part?  
25







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A. I just took it in a joking

3

manor.

4

Q. Turning to the events of the weekend of March 21-22, on which you were working as a supervisor, in addition to Wards 4A/4B, how many other wards would you have been responsible for on that weekend?

5

6

A. There were ten or eleven. I don't remember the exact number.

7

8

Q. So you would not normally then spend a great deal of time on any one particular ward?

9

10

A. Not unless there was an acute problem.

11

12

Q. On Saturday, other than the death of Allana Miller which you indicated disturbed you, was there anything particularly unusual that you noted on 4A/4B?

13

14

15

A. No.

16

17

Q. At the end of that day when you left did you have any reason to be suspicious or worried about the ward?

18

19

A. No.

20

21

22

Q. I take it when you came on on Sunday morning a number of events happened; is that

23

24

25





17 right?

A. Yes.

Q. First of all you learned that Justin Cook had died and that digoxin had been locked up?

A. Yes.

Q. How significant did you regard the lock-up of digoxin at the time you learned about

A. It is difficult to recall all the individual aspects of that day. It was significant enough for me to ask the supervisor what we were to do about it. That I can recall. That is all I can remember.

Q. I take it at that point you weren't extremely worried about the wards; is that

A. I was concerned that again the same group of nurses had had an arrest in the two nights they had been on, concern for them.

Q. Did you suspect at that point that there might be anyone who was deliberately causing that death or any other deaths?

A. No, I had no suspicion.

Q. You were then summoned to





18 Miss Geiger's office at some point you said around  
lunch time?

A. Yes.

Q. How significant did you regard  
that at the time?

A. That was extremely unusual.  
Miss Geiger doesn't to my knowledge come in on week-  
ends unless there is a big problem.

Q. Did she say anything to you or  
did you say anything to her in terms of asking her  
why she was there?

A. I can remember being very  
nervous going to her office, and as I went in the  
door I commented something to the effect we must be  
in big trouble for you to be here on Sunday.

Q. Did you have a response to  
that?

A. She just said "Yep".

Q. Did she give you an explana-  
tion as to what the big trouble was?

MS. CRONK: Excuse me, sir. I am  
sorry to interrupt my friend's cross-examination. I  
don't suggest that she is there yet, but if we are now  
going to enter into the discussions that took place  
at that meeting, it seems to me it would be quite





1  
2 proper for some of my friends in this room who have  
3 yet to stand on their feet for cross-examination to  
4 delve into the context of that meeting, its purpose,  
5 who was there --

6 THE COMMISSIONER: I'm sorry, were  
7 the police present at this meeting?

8 MS. CRONK: Well, it is my under-  
9 standing, sir, that Officer Warr was there although,  
10 according to my information, he may not have been  
11 identified as such.

12 I think my friend, perhaps inadvertently,  
13 is opening up a door that she may not have intended to  
14 open.

15 THE COMMISSIONER: Well, she may not  
16 have intended to. I am still standing by the ruling  
17 that I made, whenever I made it, a couple of days ago.

18 Carry on, Miss McIntyre. Nobody can  
19 say you haven't been warned, but on top of that even  
20 if you have been warned, I won't let you or them go  
21 any farther than you should.

22 MS. McINTYRE: Yes, Mr. Commissioner.  
23 I know I am close to the borderline and I did not  
24 intend to get into Phase II concerns.

25 THE COMMISSIONER: Yes.

MS. McINTYRE: However, Ms. Cronk did







1  
2 go through the events of this day and there were a  
3 few questions that I wanted to ask this witness,  
4 hopefully with a Phase I focus.

5 THE COMMISSIONER: Yes. All right.

6 Ms. McINTYRE: Q. At that time, did  
7 you think that the big trouble you referred to was  
8 the deaths that had occurred on Ward 4A/4B?

9 A. No. I remember being extremely  
10 upset at seeing Miss Geiger in the Hospital on the  
11 Sunday and the fact that she wanted to see me.

12 Q. At that point you knew that  
13 there was a possibility of an inquest on the Pacsai  
14 case?

15 A. Yes.

16 Q. Did it occur to you that that  
17 meeting had anything to do with the Pacsai inquest?

18 A. I may have thought that. My  
19 recollection -- there were so many things that happened  
20 that day I don't recall specifically thinking that.

21 Q. In any event at that point of  
22 the day you were somewhat concerned?

23 A. Yes.

24 Q. You were then requested to  
25 call the Trayner team not to come in to work. Did you  
view that as being significant at the time?



Radojewski  
ex. (McIntyre)

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THE COMMISSIONER: I'm sorry, did you view that as what?

MS. MCINTYRE: As being significant.

A. That was highly unusual.

Q. Were you given an explanation by anyone in Administration as to why that was being done?

A. I remember it was not a terribly adequate one. It had to do with the stress that they had undergone in the last two long night duties that they were on.

Q. The supervisors then appeared on the ward. When was that?

A. The supervisors were there for the evening shift. I don't remember how they got there, but I remember they were already there as I was coming down the hall.

Q. Were you given an explanation by anyone in Administration as to why they were there?

A. Not that I recall.

---



Q. Some of the patients you then observed being transferred off the floor?

A. Yes.

Q. Who was doing that?

A. I remember seeing Dr. Fowler, Dr. Costigan was up at one point.

Q. Is it usual for physicians to be involved in transferring patients?

A. Not the actual mechanics of it, no. The transfers were arranged through the admitting department, and they were -- they had called the wards and found empty spaces on other wards throughout the hospital and they were just sending our patients here and there.

Q. Did you ask either Dr. Fowler or the other doctors for an explanation as to why your patients were being transferred?

A. I remember calling Dr. Fowler, and I was extremely rude and demanding some sort of explanation from him. His response was; "I can't tell you anything, I just can't tell you anything". I was so rude I apologized much later.

Q. Mrs. Radojewski, there have been a number of discussions at this Commission, and some evidence given with respect to staffing on 4A/B,





1  
2 and the suggestion that there may have been a  
3 shortage of nursing staff particularly on the night  
4 shift. I take it that a number of the experienced  
5 nurses left the employ of the hospital on the transfer  
6 from the 5th floor to the 4th floor, is that right?

7 A. Yes.

8 Q. And that was due, at least in  
9 part, to the increase in shift work?

10 A. Yes. We had gone from-in a  
11 six week rotation working two weeks of long nights and  
12 four weeks of long days, to working two weeks of long  
13 days and two weeks of long nights, alternately.

14 Q. And were you able to hire  
15 replacement staff for those who left?

16 A. We hired replacement staff, how-  
17 ever, we did not -- there were not available to us  
18 experienced nurses.

19 THE COMMISSIONER: We have had that  
20 from some witness, I have forgotten which one,  
21 we have all of those figures as to how many were  
22 gone and how many were hired and what the shortage  
23 is where.

24 MS. McINTYRE: I think that is with  
25 respect to 4B.

THE COMMISSIONER: Only 4B, is it?







1  
2 MS. CRONK: It is with respect to both  
3 wards, and that was given by Mary Costello.

4 THE COMMISSIONER: We have got that now  
5 and if this witness can give us any more, then that's  
6 fine.

7 MS. McINTYRE: Yes, yes. Well,  
8 I want to ask this witness questions of a fairly  
9 general nature on this point.

10 THE COMMISSIONER: Yes, all right.

11 Q. As head nurse you would be  
12 responsible for the hiring of staff and ensuring that  
13 there was adequate nursing staff on the floor?

14 A. Yes.

15 Q. I take it there were vacancies,  
16 staff vacancies from time to time on the floor?

17 A. Yes.

18 Q. And during those periods would  
19 they be filled by relief staff?

20 A. Yes.

21 Q. So I take it that you always  
22 had sufficient numbers of staff although they may not  
23 have been as experienced as you would have preferred.

24 A. Generally, if we required relief  
25 staff for the day we did receive them, there were  
probably very few occasions where we were what I would





1  
2 call short staffed, or did not receive the relief we  
3 had requested.

4 Q. But I take it that some of your  
5 staff were not as experienced in pediatric cardiology  
6 as would be the optimum, is that right?

7 A. Some of the staff were not  
8 experienced in pediatrics because they were brand new  
9 registered nurses.

10 Q. Did you ever attribute the deaths  
11 on 4A/B to either a lack of staff or the lack of  
12 experienced staff?

13 A. No.

14 Q. Could you compare the collective  
15 experience of the Trayner team with that of the other  
16 nursing teams on Ward 4A?

17 A. Collectively when -- collectively?  
18 I'm sorry, what was the word you used?

19 THE COMMISSIONER: Compare, are they  
20 good or better than the others, that's what you mean,  
21 isn't it?

22 MS. McINTYRE: Yes.

23 THE WITNESS: All the teams were  
24 equally as competent collectively. When I hired  
25 new staff I tried to -- I wouldn't place them on a  
team that already had a lot of new staff, I would place





2 them accordingly.

3 THE COMMISSIONER: You tried to make  
4 them equal, is that right?

5 THE WITNESS: Yes.

6 THE COMMISSIONER: I don't think you can  
7 guarantee that they were equal.

8 Q. So I take it you did not attribute  
9 the fact that the deaths were occurring while the  
10 Trayner team was on to a lack of experience on their  
11 part?

12 A. No.

13 Q. And do you agree that there was  
14 a staff shortage at night?

15 A. No, I don't agree. If I can  
16 explain in general terms, there may have been the odd  
17 occasion when relief staff was requested and not  
18 available.

19 Q. Occasionally, did that occasionally  
20 happen on days as well?

21 A. Yes.

22 Q. Yesterday you discussed with Ms.  
23 Cronk the likelihood of detection of someone deliberating  
24 administering a medication by intravenous. I would  
25 like to ask you a few questions about that. When you  
were answering her questions, were you assuming





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one instance of deliberate administration, or were  
you assuming a series of instances?

A. I was assuming one instance.

MR. BROWN: I'm sorry, I didn't hear  
that answer, sir.

THE COMMISSIONER: She said she was  
assuming one instance.

9

10

11

Q. If I ask you to assume a  
deliberate administration of an I.V. medication so as  
to cause a series of deaths, and let's put the number  
at 20, would your opinion change at all?

12

A. Yes.

13

Q. In what way?

14

MR. HUNT: What opinion are we talking  
about?

15

16

17

18

THE COMMISSIONER: I think it is the  
opinion that it would be difficult to detect an  
administration intravenously of an overdose of  
digoxin.

19

20

21

MR. HUNT: There were two opinions I  
thought yesterday, one was that the chances of  
being detected were slim, and if you did it at a  
busy period it was less likely.

22

23

24

25

THE COMMISSIONER: Yes. I think the  
question applies to both, the more often you do it, I







1  
2 think even I can draw that conclusion, the more often  
3 you do it the more likely you are to be detected.

4 MS. McINTYRE: Yes, that is definitely --

5 THE COMMISSIONER: Is that what you are  
6 trying to --

7 MS. McINTYRE: Yes, that is definitely  
8 what I was directing the question to.

9 THE COMMISSIONER: Yes, all right.  
10 If the chances of detection are nil, then 20 times  
11 zero is nothing, but if your chances are 1 in 100,  
12 20 times that nil, I don't know whether that makes out  
13 to 1 in five, but it certainly improves.

14 MS. McINTYRE: A lot of probability,  
15 we have to get a statistician.

16 THE COMMISSIONER: Yes, all right, well,  
17 we have had those, too. I think that was a good  
18 answer.

19 MS. McINTYRE: Sir, I would think that  
20 while it is obvious it is perhaps worth investigating  
21 with the witness.

22 THE COMMISSIONER: Yes, all right.

23 MS. McINTYRE: Since she was qualified  
24 so carefully by Ms. Cronk to give an opinion on this  
25 point.

Q. Mrs. Radojewski, can you tell me,





in your opinion, what the chances of detection are if a single individual were to give a deliberate administration of medication so as to kill 20 infants?

MR. HUNT: Over what period of time?

THE COMMISSIONER: Yes, a different one each night you mean over a period of nine months.

MS. MCINTYRE: How about one each night for nine nights?

THE COMMISSIONER: Not each night for nine nights, nobody has suggested that, but one --

MS. MCINTYRE: Over a nine month period?

THE COMMISSIONER: Yes, all right.

Q. Do you have the assumption straight?

MS. CRONK: I don't.

THE WITNESS: I'm sorry, I am confused.

THE COMMISSIONER: Well, I don't really think it is a very fair question, but I think it is a very fair argument, Ms. McIntyre, but it isn't a fair question. You can't ask for Mrs. Radojewski to say what the chances are of detection. She has told us if it happens once the chances of detection are slim. If it happens more often the chances are greater, and I think that is a reasonable assumption. But surely to ask her what the chances are of being





1  
2 discovered, wouldn't you be better off to put that  
3 in argument?

4 MS. McINTYRE: Probably, sir.

5 THE COMMISSIONER: Yes, all right.

6 MS. McINTYRE: I assume my friends are  
7 not going to be asking further questions.

8 THE COMMISSIONER: Well, they may well  
9 but you can come back you know.

10 MS. McINTYRE: Okay.

11 Q. Let me ask you to clarify  
12 a few specific points that she asked you about, Mrs.  
13 Radojewski. With respect to an injection into an  
14 ordinary intravenous apparatus, at what height is the  
15 buretrol normally found?

16 A. The buretrol is usually about  
17 two feet above the level of the bed.

18 Q. And where would that be?

19 A. The level of the mattress, of  
20 the bed, or the patient, actually.

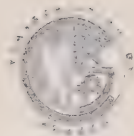
21 Q. Okay.

22 THE COMMISSIONER: That's the level of  
23 the mattress, did you say?

24 THE WITNESS: What I mean to say is  
25 about two feet above the level of the patient.

THE COMMISSIONER: That would be two





1  
2 feet above the mattress, the patient being at the  
3 mattress level.

4 Q. For an infant in a stork  
5 bed approximately how many feet off the ground would  
6 that be?

7 A. Stork beds are very high, they  
8 are higher than our normal cribs, I'm not a very  
9 good judge of height.

10 Q. Could you show us how high it  
11 would be?

12 THE COMMISSIONER: What you are really  
13 getting at -- the height it would be compared to  
14 somebody standing, is that right?

15 MS. MCINTYRE: Yes.

16 THE COMMISSIONER: Couldn't we ask that,  
17 where would it be?

18 Q. Would someone have to reach up  
19 to put an injection into the buretrol?

20 A. No. I think people of  
21 average height could reach the buretrol easy and  
22 there is a control mechanism on the intravenous  
23 pole that allows you to lower it to the height if you  
24 are really short.

25 Q. Would it be at eye level, or  
above eye level?







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A. Usually eye level.

Q. In comparison, where is the first injection site in the I.V. tubing?

A. In the tubing? It is coming down from the buretrol, the first injection site is about 6 inches to 8 inches away from the patient.

Q. How far is that from the buretrol?

THE COMMISSIONER: The buretrol is two feet above the infant and this is 6 inches from the infant, it is the sort of thing I could work out.

Q. So it is about 18 inches? Would it be apparent to someone making an observation that an injection was being made into the I.V. tubing rather than into the buretrol?

MR. HUNT: Surely that question needs more to it than that. Would it be apparent to a person? It depends where the person is standing. It depends how the person is going about making the injection; is attempting to make it appear that is not what is being done. In my submission the question is improper.

THE COMMISSIONER: Well, go ahead, ask the question and we will let Mr. Hunt deal with that,





1  
2 he will deal with it in his brilliant way.

3 MS. MCINTYRE: I am sure he will.

4 THE COMMISSIONER: Yes, all right, go  
5 ahead. Anyway, you want to know if you would be seen  
6 if you put it in, is that the question?

7 Q. My question was whether or not  
8 it would be apparent to someone else standing  
9 in the room.

10 THE COMMISSIONER: Whether it was being  
11 put into the buretrol or put in at the first  
12 injection site.

13 MS. MCINTYRE: Yes.

14 THE COMMISSIONER: Can you help us  
15 with that?

16 THE WITNESS: Yes, I think there would  
17 be a difference.

18 THE COMMISSIONER: You say there would  
19 be what?

20 THE WITNESS: There would be a dif-  
21 ference. Usually people are standing upright putting  
22 the injection into the buretrol, and often they are  
23 bending over the bed if they are putting an injection  
24 in that site that you were talking about.

25 Q. And if this was being done in  
Room 418, is the door kept open or closed to that room?





1  
2 A. The door is generally kept open.

3 MR. HUNT: Could this witness be  
4 qualified as to her ability to tell us what happens  
5 at night, because as I understood it she was always  
6 on during the day shift.  
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MS. McINTYRE: The witness has already been asked a number of questions about the night shift.

THE COMMISSIONER: Just carry on, carry on and I'll do what I can.

MS. McINTYRE: Q. All right. Do you think the observation could be made from the doorway as to whether or not an injection was being made into the buretrol or the IV injection site?

A. Yes, I do.

Q. If it was being done by someone with their back to the door, would it still be apparent?

A. From what I have observed there is usually a change in posture when someone is injecting something into the buretrol as compared to working at or close to the injection site in the patient.

MS. McINTYRE: Mr. Commissioner, is this a convenient time?

THE COMMISSIONER: Well, now we are in real trouble. How long do you expect to be?

MS. McINTYRE: I don't expect to be very much longer but I might be another 10 minutes.

THE COMMISSIONER: Ten minutes?







MS. MCINTYRE: Yes.

THE COMMISSIONER: I think if we are going to have any chance I think we will just have to shorten the lunch hour. So, could you just try to finish before 1 o'clock.

MS. MCINTYRE: Certainly. Yes, I am almost finished.

THE COMMISSIONER: Yes, all right.

MS. MCINTYRE: Q. With respect to a sage pump, there were a number of questions put to you yesterday about making injections into a sage pump. Can you explain to us how you would inject another medication into IV if there is a sage pump set up with, for example, heparin?

A. I am assuming you mean with the sage pump already in operation?

Q. Yes.

A. At the patient's bedside. You would have to remove that 60 cc syringe, you would have to disconnect the tubing from the 60 cc syringe and then inject your medication using your needle and syringe into the larger syringe.

Q. Okay. Is that a usual procedure?

A. At the bedside it would be





Radojewski, ex.  
(McIntyre)

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1  
2 unusual except if you were preparing a new syringe  
3 to put on to the sage pump.

4 Q. In your opinion if someone was  
5 seen doing that would it be thought to be peculiar,  
6 would it be noticed?

7 A. Can you repeat that for me,  
8 please?

9 Q. If someone were observed doing  
10 that, the procedure you have explained, would it be  
11 thought to be unusual?

12 A. At the bedside I would think  
13 it unusual.

14 Q. Why do you say at the bedside,  
15 where would this normally be done?

16 A. If you were preparing a syringe,  
17 a replacement syringe for the sage pump, it is  
18 usual to do that preparation in the medication and  
19 treatment room because that's where our drugs are  
20 stored. We tend not to keep them at the bedside.

21 Q. How long would that procedure  
22 take?

23 A. The procedure of taking the syringe  
24 off of the sage pump and disconnecting the tubing,  
25 drawing back on the barrel of the syringe and  
injecting.





Q. And reconnecting it?

A. And reconnecting, if you were good at getting the syringe back in, because it is difficult to get it back in, I would say at least five minutes.

Q. And I think you told us yesterday that there is not normally an injection site hook-up with the sage pump, is that right?

A. That's right.

Q. However, there would be another procedure would there not for injecting an alternative medication when you had a sage pump hooked up, and that would be by doing it directly into the tubing?

A. The sage pump could also be used for administering small doses of antibiotics and in those instances a disposable injection site was attached between the syringe and between the tubing. It is a very small piece of equipment and that's the injection site that you would use.

Q. If there is no injection site, is there another way of injecting a medication directly into the tubing by disconnecting the tubing from the sage pump?

A. Yes. If you disconnect the tubing from the syringe on the sage pump and connect





2 your syringe without a needle and just push it into  
3 that small tubing.

4 Q. Is that something that is  
5 normally done?

6 A. No.

7 Q. Would that be noticed, in your  
8 opinion?

9 A. It is very unusual, I am sure  
10 it would be.

11 Q. How long would that take?

12 A. If you were to disconnect the  
13 tubing and put your syringe on the end of it,  
14 depending on the volume you had in the syringe you  
15 were using, it may take a minute or more because you  
16 then may run the danger of -- there is too much  
17 tension created in that very small narrow tubing  
18 if you inject it very quickly.

19 MS. McINTYRE: Thank you, I have no  
20 further questions.

21 THE COMMISSIONER: Yes, all right.  
22 Well now, until 2:15.

23 ---Luncheon recess.  
24  
25

- - - -







--- on resuming.

THE COMMISSIONER: Just on the timing problem, Mr. Hunt. I know you have said that your maximum was two hours. If you go a whole two hours that's the whole afternoon and I don't know how long Mr. Percival will be.

Mr. Percival, how long do you think you will be?

MR. PERCIVAL: Three-quarters of an hour at the most.

THE COMMISSIONER: Well, can we look at the thing again at a quarter past three and you may be prepared to step down.

MR. HUNT: I hope to be finished by a quarter past three.

THE COMMISSIONER: Well, that's the best of all possible worlds.

MR. HUNT: Taking out all irrelevant questions I won't be very long.

THE COMMISSIONER: All right.

CROSS-EXAMINATION BY MR. HUNT:

Q. Mrs. Radojewski, my name is Hunt, and we appear on behalf of the Attorney General and Crown Attorneys and the Coroners at this Commission.





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3 You told us on Monday that the busy  
4 times in the Hospital as on the night shift in any  
5 event were at eight o'clock and nine o'clock, again  
6 at midnight and then at four in the morning. You also  
7 indicated later in your evidence that in terms of when  
8 would be a time when someone, if they want to administer  
9 a dose of digoxin to someone to cause them harm ought  
10 to do that or could do that, in order to minimize the  
11 chance of detection in your view it would be at one  
12 of the busy times.

13 Do I take it that you are referring to  
14 the same times when you say that as you gave us the  
15 other day as being the busy times on the long night  
16 shift?

17 A. Yes.

18 Q. All right. So that if I was  
19 working there and interested in intentionally harming  
20 a child by means of an overdose of digoxin the times  
21 to do it would be at eight o'clock or nine o'clock,  
22 midnight and four o'clock; is that right?

23 A. Yes.

24 Q. All right. Now, you indicated  
25 that there was a period, or a period of time that the  
nurses could break up into coffee breaks and lunch or  
dinner and that the lunch or dinner break would usually





1  
2 be around 1:30 and thereafter for an hour or so when  
3 it wasn't too busy.

4 A. The recollection that I have  
5 from when I actually worked nights and looking at what  
6 I perceived the workload to be on long nights, it's  
7 not etched in stone.

8 Q. No, I appreciate that, but  
9 you are saying that according to your experience that  
10 is the usual time when the meal was eaten, somewhere  
11 from 1:30 to 2:30 I suppose, that period?

12 A. Yes.

13 Q. All right. Could I suggest  
14 to you to see what your thought is that another time  
15 when someone who was interested in intentionally  
16 harming the babies could do this and minimize their  
17 chances of detection would be when they were relieving  
18 someone who has gone to take a coffee break or for  
19 their dinner?

20 A. That's a possibility.

21 Q. Because in those periods of  
22 time the person relieving would know that for some  
23 relatively fixed period the other person was going to  
24 be away and unlikely to return?

25 A. Yes.

Q. And is it your evidence that





usually one coffee break is taken by the nurses prior to starting their dinner at whatever time that might be, at 1:30?

A. Again, the recollection that I have from when I worked the long nights is that often there was time to have a short coffee break in what I call the latter part of the evening shift before midnight.

Q. All right.

A. There is usually some time there.

Q. All right.

THE COMMISSIONER: I am now thinking about what we were talking about this morning. Supposing a nurse wants to, having administered medicine, wants to have coffee, is she not permitted to leave, assuming she is not on constant care, is she not permitted to leave the room to go and write up the medicine administration?

THE WITNESS: No.

THE COMMISSIONER: They can do that?

THE WITNESS: Oh, yes.

THE COMMISSIONER: Do they have to be relieved under those circumstances? I mean they are just going to write it up?







1  
2 THE WITNESS: No.

3 THE COMMISSIONER: That's legitimate?

4 THE WITNESS: Yes.

5 THE COMMISSIONER: I think you said  
6 ideally that's the way it should be done, am I right?

7 THE WITNESS: Yes.

8 THE COMMISSIONER: Yes, all right.

9 MR. HUNT: Q. And I take it with  
10 respect to coffee breaks that is flexible to some  
11 degree in that it might depend on the state a patient  
12 is in at a given point in time as to whether or not  
13 it would be appropriate to take the coffee break at  
14 some point?

15 A. It has to do with, yes, whether  
16 or not a patient is -- could you repeat the last part  
17 of that?

18 Q. I can't even remember the  
19 last part of it.

20 A. Could I explain when I think  
21 they take their coffee breaks?

22 Q. I guess what I was getting at  
23 is this, that you can't say that a person will take  
24 their coffee break always at the same time in the  
25 evening because it may be the necessity of looking  
after the child would have to take precedence at that





1  
2 point and they would have to delay it or maybe take  
3 it a little earlier?

4 A. Yes.

5 Q. In terms of relieving people  
6 in order to take a coffee break and take their lunch,  
7 does the team leader have any responsibility?

8 A. Yes, she has some responsibility  
9 in that in my experience it may even be the team  
10 leader on occasion who relieves a nurse who is doing  
11 constant care or shared care for her breaks. Very  
12 often the team leader is used as the relief person  
13 when a nurse who has five or six patients who are  
14 well settled that the team leader may then be that  
15 person's relief nurse and the team leader has to be  
16 aware of someone who is going off on their breaks so  
17 that she knows that there are adequate nurses left on  
18 the floor.  
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3 Q. And because the team leader is  
4 responsible for all of the nurses and their patients,  
5 I take it she is more or less floating to some extent  
6 in terms of what she is doing during the course of  
7 a shift and would be able to plug into a situation  
8 where someone wanted to take a coffee break or take  
9 dinner?

10 A. Usually they come to her and  
11 say, "Is it okay if I go on my break now?"

12 Q. Now you told my friend  
13 Ms. Cronk about an incident that you recalled, a  
14 single incident that you recalled that was in the nature  
15 of a disagreement as between Phyllis Trayner and  
16 Susan Nelles.

17 Now I don't intend to pursue other  
18 pieces of information that we have heard with respect  
19 to that except to this extent: we have heard from  
20 nursing supervisor Coulson with respect to the conflict,  
21 and I am looking at Volume 108, page 4401, Mr.  
22 Commissioner, and without reading it to you she  
23 said that she agreed that the conflict as between the  
24 two was something that was known to most of the people  
25 who were connected with the ward in any capacity.

Would you agree with that?

A. I can't disagree with Miss





1  
2 Coulson's perception.

3 Q. She also said that from her point  
4 of view she could not remember any other two nurses  
5 on the ward who had that type of conflict that  
6 everybody was aware of. Would you agree with that?

7 A. That may be Miss Coulson's  
8 experience.

9 Q. Well, I take it from your  
10 evidence that you really were telling us that you only  
11 had knowledge of one incident with respect to the  
12 conflict, and that was the one you described for us.

13 A. I had knowledge of one what  
14 I considered to be a serious enough incident to speak  
15 to them about.

16 Q. But you are not suggesting to us  
17 that the fact of the conflict was something that  
18 was restricted to only your knowledge and only your  
19 knowlege arising out of the one incident.

20 A. Would you repeat that for me,  
21 please?

22 Q. You are not suggesting by  
23 virtue of the evidence that you gave that the fact  
24 of the conflict was something that only you knew about  
25 and it was restricted only to the one incident.

A. Again, that is the only serious







1  
2 incident that I was made aware of, serious enough to  
3 follow up.

4 Q. Now, when they approached you  
5 with respect to that one incident I take it you  
6 proposed a solution to the problem.

7 A. My solution was to let them  
8 come to grips with their, for want of a better word,  
9 their disagreement with each other, to take each  
10 other's opinions into consideration and to have respect  
11 for each other's knowledge. And if they didn't, then  
12 I would step in and do something further.

13 Q. And the something that you would  
14 do if you stepped in I take it would involve switching  
15 them or taking one of them off the team.

16 A. Yes.

17 Q. At some point did they both come  
18 to you and tell you that they had worked out their  
19 problems?

20 A. Yes, they had.

21 Q. And at that point did they tell  
22 you that they felt much better about working with  
23 each other?

24 A. Yes.

25 Q. Do you remember when that  
occurred?





1

2

A. No; I'm sorry, I don't recall.

3

Q. Was it in 1980 or 1981?

4

A. I don't recall for sure.

5

Q. As far as you were aware after that point in time when they both came to you and said they felt better about working with each other, the difficulties as between them were over?

6

9

A. No. I don't know that they were over. There were no serious confrontations between the two of them that I was made aware of. What I observed and what I felt was the general impression that they were getting along.

12

13

Q. You said twice -- you qualified your answer by the phrase, "that I was made aware of." I take it there may be things that happened that you weren't made aware of.

14

15

16

A. I am sure there were.

17

18

Q. Now, did you know whether or not Susan Nelles and Phyllis Trayner socialized at all outside the hospital?

19

20

A. I knew on occasion that they had gone out for something to eat after a 12 hour shift.

21

22

Q. That is the two of them?

23

A. It could have been two or more.

24

25

Q. Did you yourself ever attend when





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1  
2 the two of them were out for dinner after?

3 A. Yes.

4 Q. How many occasions would that  
5 have been?

6 A. Just once.

7 Q. Do you recall when that was?

8 A. My only recollection is that  
9 we were wearing - we were not wearing winter  
10 clothing. I can't remember anything further.

11 Q. That suggests probably some time  
12 in the summer or fall of 1980?

13 A. That is possible, yes.

14 Q. Well, from your observations  
15 of them in the context of the hospital and the social  
16 settings were you able to or did you come to any  
17 conclusion as to whether or not there was any kind of  
18 a bond between the two of them?

19 A. I don't remember being struck  
20 by something out of the ordinary. There is in my  
21 experience a bond between a group of nurses that  
22 work together constantly.

23 Q. Is that what you are saying is  
24 your observation of the sort of relationship that  
25 they had?

A. Yes.





1  
2 Q. Now you have been referred a  
3 number of times to an interview that you had with Mr.  
4 McGee and Mr. Wiley, the Crown attorneys, on  
5 December 1st of 1981. And there was some discussion  
6 with respect to the use of the word "overridden".

7 Do you have a copy of that?

8 A. Yes.

9 Q. And I think your evidence was -  
10 it came up in the context of this disagreement between  
11 the two, and the suggestion was that you had told  
12 the Crown attorneys that Susan overrode Phyllis'  
13 order to call the arrest team. And I think you ob-  
14 jected to the use of the word "overridden" or "overrode"  
15 and suggested that it was not your recollection that  
16 you used that word.

17 Have I fairly summarized the exchange  
18 on that point?

19 A. Yes.

20 Q. And, first of all, do you have  
21 any notes of your own with respect to this meeting?

22 A. - No.

23 Q. So you weren't taking notes  
24 during the course of the meeting?

25 A. No.

Q. You didn't make notes afterwards?







1  
2 A. No.

3 Q. About it? And you are aware  
4 that during the course of the meeting Mr. Wiley was  
5 making notes?

6 A. He was not making notes  
7 constantly. He stopped to listen while I talked.

8 Q. And then he made a note?

9 A. He made some notes while I was  
10 there, but he was not writing constantly.

11 Q. Well, it would seem fairly normal  
12 to me to listen to what someone said before making  
13 a note. Would you agree?

14 A. I put it in the context of a  
15 comparison as between when I was interviewed by the  
16 police, and it was my feeling at that time that people  
17 were writing pretty well all the time that I was talk-  
18 ing.

19 Q. Well, if it is Mr. Wiley's  
20 recollection that you used the word "overrode" or  
21 "overridden" and that he wrote it down, I take it  
22 you have no basis other than your memory of the incident  
23 to dispute that.

24 A. That's right.

25 Q. Now you have told us as well that  
you did not think that the question of splitting up the





1  
2 team was ever seriously discussed.

3  
4 Now frankly we have heard from a  
5 number of witnesses that preceded you who have all  
6 spoken of discussions of splitting up the team, and  
7 I can refer you to their evidence if that is necessary,  
8 but I don't wish to, but they include Carol Brown,  
9 Mrs. Costello, Bertha Bell, Lynn Johnston and Meredith  
10 Frise.

11  
12 Examination of her evidence suggests  
13 that it was discussed not just once but on a number of  
14 occasions both formally and informally and indeed  
15 you have acknowledged it is recorded in one of the  
16 ward meeting books for the month of October.

17  
18 In light of the evidence that we have  
19 heard and the fact that it is there, I have some  
20 measure of surprise at your suggestion that it was  
21 never seriously discussed. What I want to ask you:  
22 is this one of the matters that perhaps was never  
23 discussed with you?

24  
25 A. There may well have been dis-  
cussions. I just don't recall them.

Q. Well, the decision to break up  
a nursing team and perhaps the broad reaching effect  
that might have on the other teams is a  
fairly serious decision. And I take it it is not





1  
2 something that occurs with any degree of frequency.

3 A. That's right.

4 Q. So this issue of splitting up  
5 the team is something that if it had been discussed  
6 with you, you are likely to remember it, aren't you?

7 A. There has been so much to  
8 remember over three and a half years that I just don't  
9 recall.

10 Q. Is there any reason that you can  
11 think of that the people involved wouldn't have dis-  
12 cussed that issue with you?

13 A. No, I can't think of any issue  
14 where they would not have discussed it.

15 Q. You can't think of any reason  
16 they would not have discussed it?

17 The question of psychiatric assistance  
18 for the nurses has also been raised here in the evidence  
19 by some of the witnesses. Are you aware of conversa-  
20 tions about that?

21 A. I am --

22 MR. ROLAND: I think my friend should  
23 put that in some temporal context.

24 MR. HUNT: Sure.

25 MR. ROLAND: Because there was  
certainly psychiatric assistance after Susan Nelles





BB  
M/PS

1  
2 was arrested.

3 MR. HUNT: I am referring to a period  
4 of time from August of 1980 through to some time in  
5 October of 1980. That is the summer months and the  
6 early fall.

7 Q. We have heard that the question  
8 of nurses who were under considerable stress at that  
9 time raised the issue of the possibility of  
10 psychiatric counselling to assist them during that  
11 period of time, and I ask you whether you are aware  
12 of discussions about that at that point in time.

13 A. Some time in late August we  
14 knew that a psychiatrist was being assigned to our  
15 ward and it was our hope that he would be able to give  
16 some time to the nursing staff to deal with the  
17 problems of the stress of patients dying.

18 Q. Did you discuss the possibility  
19 of receiving psychiatric therapy with any of the  
20 nurses on the team? That is the Trayner team.  
21  
22  
23  
24  
25

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Interd  
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1  
2 A. I don't recall.

3 Q. Well, do you recall at some  
4 point in time discussing that matter with Lynn  
5 Johnstone?

6 A. I don't recall.

7 Q. Well, Lynn Johnstone testified,  
8 and I am looking at Volume 103, page 3475 through to  
9 3477, and she indicated, if I can summarize the bulk  
10 of this, that she spoke to all of the members of the  
11 Trayner team and others as well about this matter.  
12 She spoke to Bertha Bell in addition. Then she spoke  
13 to you, and with respect to all of the other nurses  
14 that she spoke to, she said they were all in favour  
15 of the idea - I am now looking at page 3477, about  
16 line 6.

17 "Q. Were they in favour of the  
18 idea?"

19 "A. Yes, they were."

20 "Q. Was there anybody opposed to  
21 the idea?"

22 "A. No."

23 "Q. What was Nurse Radojewski's  
24 response?"

25 "A. She thanked me for my concern.  
She felt at the time that they were





1  
2 supporting them enough, "them" meaning  
3 herself and Mary Costello."

4 "Q. Yes."

5 "A. That was about it."

6 "Q. I take it it didn't happen  
7 at that time in any event?"

8 "A. No."

9 Now she seems to suggest that there  
10 was a very favourable response to this particular  
11 issue amongst the nurses, and with Bertha Bell, and  
12 certainly on her part, that when she spoke to you  
13 you indicated to her that really it wasn't necessary  
14 that there was some support being given to these  
15 nurses from within, or from yourself and Mary  
16 Costello. Now, do you recall that?

17 A. No, I don't recall the  
18 conversation.

19 Q. Well I take it then that the  
20 issue of psychiatric assistance doesn't stand out in  
21 your mind as being a very significant one in any  
22 event in the fall of 1980?

23 A. The issue of the psychiatrist  
24 does stand out, because when he did appear on the  
25 ward it was realized that he had very limited time,  
and the time he had was available for our patients and





1  
2 not for our nursing staff. I am not sure in what  
3 context Miss Johnstone's comments, what time frame,  
4 I'm sorry, they are in, but we then turned to look  
5 at someone else who might be made available.

6 Q. Well nothing was done in  
7 terms of that I think we have heard until some time  
8 in April 1981.

9 A. I believe we had discussions  
10 in early January of the need for Andrea Frewin,  
11 because if we couldn't get someone like a psychiatrist  
12 worked into our budget for our nurses then we would  
13 look to getting someone within the nursing department  
14 who could help us as well, and Andrea Frewin was our  
15 Mental Health Nurse.

16 Q. Is your recollection of this  
17 that it was a budgetary matter that prevented the  
18 issue from going further in the fall of 1980?

19 A. There were some issues raised  
20 about budget, yes.

21 Q. But you don't recall in any  
22 event the discussion with Mrs. Johnstone that she has  
23 related?

24 A. No, I don't.

25 Q. You have told us that one of  
the rules or policies was that a case where a child





1  
2 died within 24 hours of admission to the Hospital was  
3 one that was reported to the Coroner.

4 A. It was my understanding, yes.

5 Q. Now before June of 1980, before  
6 this period began, in your experience did it often  
7 occur that a child would die on the ward within 24  
8 hours of admission to the Hospital?

9 A. I don't recall there being  
10 very many. Are you -- I'm sorry, just in the context  
11 of 5A?

12 Q. Well in the context of 5A  
13 certainly, and indeed your experience with cardiology  
14 patients totally, is it a usual thing, or perhaps that  
15 is overstating it, does it often occur that a patient  
16 will die on the ward within 24 hours of being admitted  
17 to the Hospital?

18 A. To the best of my recollection  
19 it didn't occur often.

20 Q. Would you say it is an  
21 unusual event then when a child dies on the ward within  
22 24 hours of admission?

23 A. I would have to qualify that  
24 by saying it depended on the condition the child  
25 arrived on the ward.

Q. We are not talking --







Radojewski  
cr.ex. (Hunt)

1  
2 THE COMMISSIONER: Obviously it would.  
3 But I think what you mean is is it unusual for the  
4 child, if a child does die - don't children die  
5 within 24 hours? Most of the children who died was  
6 it within 24 hours of their arrival?

7 THE WITNESS: Quite a few of them it  
8 was.

9 MR. HUNT: Q. We are talking about  
10 on the ward, not anywhere else but on the ward. Your  
11 recollection I take it from your evidence is that it  
12 didn't often occur that they died there on the ward  
13 within 24 hours of their admission?

14 A. Yes.

15 Q. So it is an unusual event  
16 when that happens?

17 THE COMMISSIONER: I thought the answer  
18 was the other way around, but perhaps I am wrong. You  
19 say it is quite usual, or not?

20 THE WITNESS: I am confused whether  
21 you are talking about two separate issues here.

22 MR. HUNT: Maybe we are.

23 MS. McINTYRE: Mr. Commissioner, I  
24 think there may be some confusion in the time sequence  
25 here because I think Mrs. Radojewski is referring to  
before, the period before July 1980 and now the





witness is looking at these deaths, the 36 deaths, so there may be some confusion there.

MR. HUNT: Q. Let's stick to before June of 1980, okay, this is before the events of the nine-month period. That is where I am directing my question. In that time period in your experience was it an unusual thing for a child to die on the ward within 24 hours of being admitted to the Hospital?

A. It happens on occasion.

Q. On occasion. My question is: Was it an unusual event when it did happen?

A. Unusual in that it was surprising, but again I have to qualify that on the condition the patient arrived in.

Q. That really doesn't go to the question of sort of whether or not it was a frequent or usual event. I think you are really saying that it happened from time to time, it may have been that the children's condition was such that it was completely answerable by that, but when it happened it was significant because they died on the ward within such a short time of having come into the Hospital?

A. Yes.

Q. Now, we come to the events of June 30th through to March 22nd. The evidence that





1  
2 we have here, and I stand to be corrected if I am  
3 wrong, is that no less than five children, five of the  
4 36 children that we are enquiring into here died within  
5 24 hours of their admission to the ward; and those  
6 for the Commissioner's assistance are Baby Shrum, who  
7 was admitted on August 8 at 2128 hours, who died on  
8 August 9th at 1945 hours.

9 The second one was Baby MacDonald,  
10 whowas admitted on the 5th of December of 1980 and  
11 died on the 13th of December - I'm sorry, admitted on  
12 the 12th of December and died on the 13th of December,  
13 admitted at 1352 and died at 4:30 in the morning the  
14 following morning.

15 The third one was Baby Gosselin, who  
16 was admitted on the 17th of December at 3:00 a.m.  
17 and died on the 18th of December at 3:16 a.m. So I  
18 guess we have 16 minutes over the 24 hours in connec-  
19 tion with that.

20 Baby Warner, who was admitted on the  
21 6th of March at 1936 and died on the 7th of March at  
22 3:40 a.m.

23 Baby Inwood, who was admitted on the  
24 11th of March at 1456 and died on the 12th of March  
25 at 3:00 a.m.

THE COMMISSIONER: I have it on the  
13th of March. Am I wrong?





Radojewski  
cr.ex. (Hunt)

CC8

1  
2 MR. HUNT: I am sorry, the 13th, then  
3 was admitted on the 12th?

4 THE COMMISSIONER: Admitted on the  
5 11th I have.

6 MR. LABOW: Admission on the 11th  
7 and died in the early morning of the 13th.

8 MR. HUNT: So that one is over 24  
9 hours. So we have four.

10 THE COMMISSIONER: All right.

11 Now, Mr. Shinehoft?

12 MR. SHINEHOFT: I don't know if my  
13 friend is including Baby Pacsai in his time frame or  
14 not, but my understanding is that the baby died within  
15 24 hours.

16 THE COMMISSIONER: Yes. Well, it is  
17 the 11th of March admission and the death is 10:10 on  
18 the morning of the 12th of March, so I would think it  
19 was.

20 MR. HUNT: I think that is the one  
21 I probably should have instead of Inwood.

22 THE COMMISSIONER: Instead of Inwood,  
23 all right.

24 MR. HUNT: All right. So we are back  
25 to five, and my friend Mr. Roland keeps advising me  
that the one baby was 16 minutes over the 24 hours, so







1  
2 if there is a dispute about that, my friend can take  
3 it up.

4 Q. I am suggesting there are  
5 five babies between the 30th of June, really it is  
6 between the 8th of August and the 12th of March, which  
7 is I suppose about seven months, five babies that  
8 died within 24 hours of being admitted, or within  
9 the time frame in which it was the rule or the  
10 policy to report those deaths to the Coroner. None  
11 of those, with the exception of Pacsai, so four of  
12 those five were not reported to the Coroner.

13 Now, first of all, let me ask you  
14 is the fact that there were five within that seven-  
15 month period unusual when compared to your experience  
16 prior to the end of June 1980?

17 A. I don't know that I would have  
18 had an opportunity to look at the deaths collectively  
19 and figure out that there had been the five to compare.

20 Q. I am not suggesting, believe  
21 me, for a moment that you were the one who was supposed  
22 to be doing this or anything like that. I am just  
23 saying, in your experience, is that not most unusual  
24 to have five of them that die within that period of  
25 time after being admitted to the Hospital in a seven-  
month period?





Radojewski  
cr.ex. (Hunt)

1  
2 MR. ROLAND: I wonder if Mr. Hunt  
3 has some information he is going to tell us about.  
4 We haven't seen any information like this statistically  
5 from the Hospital. All I can recall that makes this,  
6 whatever the witness is going to say, she may be going  
7 to say nothing, whether it is accurate or not.

8 THE COMMISSIONER: Yes.

9 MR. ROLAND: If he has some informa-  
10 tion that we have not seen on that, and maybe there  
11 is some, it seems to me fair to the witness and to  
12 this Inquiry that he let us know, because he is  
13 leaving us with the impression that this is unusual,  
14 and it may not be unusual at all, I just don't know.

15 THE COMMISSIONER: I must say I would  
16 have preferred that, just as I would have preferred  
17 when the witness was asked about the number of deaths  
18 on the ward before, that at least she be able to  
19 see the --

20 MR. HUNT: I don't have those  
21 statistics. I assume the Hospital will bring them  
22 forward if they want to.

23 MR. ROLAND: That is a little unfair,  
24 Mr. Hunt. This is the first time this matter has been  
25 raised in this way, and Mr. Hunt approaches it as if  
he knows the answer.





1  
2 MR. HUNT: I suspect the answer and  
3 that is what I'm trying to get at.

4 THE COMMISSIONER: I am going to  
5 allow it, but if you really don't know the answer,  
6 that's not a bad answer.

7 THE WITNESS: Because I really don't,  
8 I am sorry.

9 MR. HUNT: Q. Now, you have also  
10 said that Pacsai was the first case where you were  
11 involved, where there was suggestion of the Coroner  
12 being called in, or a Coroner's inquest, that is what  
13 I want to clarify.

14 MS. MCINTYRE: I'm sorry, I believe  
15 she also said in Velasquez' case she knew the  
16 Coroner had been contacted.

17 MR. HUNT: This is what I am trying  
18 to get at.

19 Q. The Pacsai case was not the  
20 first case where you had any experience with the fact  
21 that the Coroner was being asked to investigate?

22 A. No.

23 Q. What I think perhaps then you  
24 were saying, I don't know whether I missed it, Pacsai  
25 was the first case where you were under the impression  
there was going to be a Coroner's Inquest?

A. Yes.







5MB. 15  
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1  
2 Q Okay. Is it a significant  
3 event with respect to a death, it becomes known that  
4 the coroner is being asked to investigate?

5 A A significant event to myself?

6 Q Well, in the sense that people  
7 on the ward, nurses know that, that this case, this  
8 death is resulting in a coroner's investigation, that  
9 means that the chart will have to be examined by  
10 the coroner's representative, there may be questions  
11 asked about it, it is significant in the sense that  
12 it is a matter of some note; it may not require any  
13 action but it is a matter of some note of the people  
involved?

14 A It is noted by people, it is  
15 an impression I am left with that people take notice  
of it.

16 Q Okay. But you have no  
17 recollection of there being any suggestion in January  
18 of 1981 that the death of Baby Estrella was going  
19 to be investigated by the coroner?

20 A I don't recall.

21 Q All right. And I am suggesting  
22 to you that if the death of Baby Estrella in January  
23 had been one that was suggested was going to be  
24 investigated by the coroner at that time, it would  
25







1  
2 be a matter that you would have taken some cognizance  
3 of?

4 A. If I had in fact been told, yes.

5 Q. All right. Is it not likely  
6 if that was going to be the case in January that you  
7 would have been told that then?

8 A. It is likely, yes.

9 Q. All right. Now, we have had  
10 some discussion by witnesses preceding you with  
11 respect to the issue of euthanasia, that is mercy  
12 killing. I ask you, did you have any discussion with  
13 any nurse on 4A/4B of that topic?

14 A. Not that I recall, no.

15 Q. Now, did you ever hear it  
16 discussed by nurses?

17 A. I don't recall.

18 Q. Did you ever have a discussion  
19 with any nurse about the quality of life that some  
20 of the babies on those wards were going to have in  
21 front of them?

22 A. I may have had.

23 Q. All right. Do you have any  
24 recollection of any conversation along those lines  
25 with anyone?

A. I remember talking with Susan





1  
2 Nelles and it came up in the context that she had  
3 mentioned that her brother found it easier to cope  
4 with children who had died by looking at the quality  
5 of life that may have been ahead of them.

6 Q All right.

7 A It was his way of grieving.

8 Q All right. And how did that  
9 conversation come up?

10 A I don't recall at this moment  
11 how it came up.

12 Q Do you remember when the  
13 conversation took place?

14 A No.

15 Q Did she express any thoughts  
16 of her own with respect to her brother's approach to  
17 baby deaths?

18 A Not that I recall.

19 Q Was that discussed with her  
20 once or more than once?

21 A Excuse me, Mr. Hunt, I don't  
22 think it was in relation to baby deaths, that was just  
23 his philosophy of grieving about patients who had died.

24 Q Well, when you discussed it  
25 with her, in what context was it being discussed, in  
the context of a baby death?





D.4

2 A. I don't recall the circumstances  
3 surrounding the discussion.

4 Q Did it take place in the  
5 Hospital or outside?

6 A. In the Hospital.

7 Q You do recall being interviewed  
8 by Mr. McGee and Mr. Wiley on the 1st of December,  
9 1981 and at that time I suggest to you that you told  
10 them in connection with your conversation with Susan  
11 Nelles about her brother and his views that she asked  
12 you, that is, Susan asked you how you felt about the  
13 two of them, that is, her and her brother working on  
14 the same floor, that you said it didn't matter to you  
15 as long as they did their jobs and that she once told  
16 you or that the hospital in Vancouver had suggested  
17 it didn't like them working together and she once  
18 had told you that her brother's philosophy regarding  
19 the babies had to do with the quality of life that  
20 he said to her that one couldn't grieve or be sorry  
21 when the babies died because the quality of their  
22 life would be so poor, perhaps it was better that  
23 they died.

24 Now, do you recall making that statement  
25 to Messrs. Wiley and McGee?

26 A. Not verbatim, but the idea.





Q All right. Again, you weren't taking notes at this meeting and if Mr. Wiley indicates that in your account of that conversation what you said was that the conversation involved her brother's philosophy regarding baby deaths and the quality of their life, do you have any basis to disagree with that?

THE COMMISSIONER: I'm sorry. Yes?

MS. McINTYRE: Mr. Commissioner, the statement is regarding babies and not baby deaths, to be fair to the witness.

MR. HUNT: All right, I'm sorry, that is quite so.

Q Regarding the babies and the quality of their life, do you have anything to disagree with that?

A. No.

Q All right. And it is also indicated by Mr. Wiley that in the conversation it was told that part of her brother's philosophy was that one couldn't grieve or be sorry when the babies died because the quality of their life would be so poor perhaps it was better that they died, would you disagree with that?

A. It's a poor choice of words,







1  
2 but I can't disagree with it.

3 Q What do you mean it's a poor  
4 choice of words?

5 A Either on my part of Mr. Wiley's  
6 part.

7 Q You're not suggesting in any  
8 way if the words aren't exact that the essence of  
9 what you were saying was not taken down correctly?

10 A No, I think the essence was  
11 taken down.

12 Q All right. So, does that  
13 assist you in refreshing your memory with respect to  
14 that particular conversation?

15 A I'm sorry, I'm confused, which  
16 conversation?

17 Q This conversation that we are  
18 dealing with.

19 A With Mr. Wiley or with --

20 Q Yes, with Mr. Wiley -- well,  
21 with Susan Nelles, I'm sorry.

22 A As to when I had it?

23 Q Well, as to what was discussed?

24 A No, I'm sorry.

25 Q All right. You see, you have  
just told us that the conversation so far as you can





1  
2 remember didn't have anything to do with babies  
3 dying and I am suggesting to you that in December of  
4 1981 when you discussed the matter with Mr. Wiley it  
5 did have to do with the babies dying?

6 THE COMMISSIONER: Just a moment. Yes?

7 MS. McINTYRE: I'm sorry to rise again,  
8 Mr. Commissioner, but what the witness has said was,  
9 she couldn't recall if it was discussed in the  
10 context of a baby death. I understood from that as  
11 to her recollection as to when the conversation  
12 with Susan Nelles was taking place and she didn't  
13 remember it taking place in the context of a baby  
14 death, which is something quite different than Mr.  
15 Hunt is now suggesting she said.

16 MR. HUNT: I thought she said both.

17 THE COMMISSIONER: Well, I am having  
18 some trouble with the subtlety of all of this. Mr.  
19 Brown, can you help us?

20 MR. BROWN: Well, more than the  
21 subtlety of all of this, it's all very interesting to  
22 know Dr. David Nelles' views on the quality of life.  
23 How that is relevant to the cause of death is beyond  
24 me. If there is something as to Miss Nelles' opinion  
25 as to the quality of life and euthanasia, that might  
be of interest.





1  
2 THE COMMISSIONER: Well, that is what  
3 we are getting at I think.

4 MR. BROWN: Well, perhaps, and perhaps  
5 in that regard Mr. Hunt I don't think has finished  
6 reading the paragraph in relation to that discussion  
7 and perhaps I anticipate him.

8 MR. HUNT: My next question.

9 THE COMMISSIONER: Yes, all right. Yes,  
10 Mr. Labow?

11 MR. LABOW: I'm sorry, Mr. Commissioner,  
12 but before we get into that, could I now make a formal  
13 request that other counsel be given that statement  
14 so that we too can follow along. Both Miss Cronk and  
15 Mr. Hunt have made reference to that statement and  
16 I think it is time now that other counsel be given  
17 an opportunity to see it.

18 THE COMMISSIONER: What do you say,  
19 Miss McIntyre?

20 MS. MCINTYRE: Mr. Commissioner, I  
21 have a real problem with this particular piece of  
22 paper that I would not characterize as a statement.  
23 It is my understanding that it is no way a transcript  
24 of what happened at the meeting but it is rather a  
25 summary that was made at some point after the meeting  
and from this witness' point of view is not an





1  
2 accurate reflection of what was said at the meeting  
3 and therefore I have got real problems with it.

4 THE COMMISSIONER: Well, that goes to  
5 the weight of it. I am really asking you what to do  
6 with Mr. Labow's request.

7 MS. MCINTYRE: I think I am going to  
8 have to object to this being put in on that basis.

9 THE COMMISSIONER: On what basis, I'm  
10 sorry? What basis are you objecting to? You see,  
11 remember, I have made a ruling on the matter that  
12 there comes a time when too many counsel have  
13 referred to it that it seems to be unfair to keep  
14 it away from everybody.

15 MS. MCINTYRE: I understand. Well,  
16 there are just so many inaccuracies that it could be  
17 prejudicial.

18 MR. HUNT: Well, that's all editorial  
19 comment on my friend's part.

20 THE COMMISSIONER: That goes to weight  
21 and you will have a chance to go back at it if you  
22 want to, but remember, the statement does not become  
23 evidence, it is not becoming an exhibit or anything  
24 like that unless you consent or somebody asks and  
25 they can justify it becoming one. It is purely a  
question of other counsel seeing it.







1  
2 MS. MCINTYRE: Well, if it's not going  
3 to be made an exhibit I guess the other counsel should  
4 have an opportunity to see it.

5 THE COMMISSIONER: Well, that seems  
6 to resolve that problem. At the break then we will  
7 have a copy.

8 MS. CRONK: I will see to it, sir.

9 THE COMMISSIONER: Yes, thank you.

10 MR. HUNT: Q My last question in the  
11 area. Can you tell us whether or not Susan Nelles  
12 expressed any views with respect to the philosophy  
13 of her brother that was discussed between the two of  
14 you?

15 A No, I don't recall.

16 Q You don't recall whether she  
17 did express any views of her own?

18 A That's right.

19 MR. HUNT: All right. Now, I am  
20 mindful of the time, Mr. Commissioner.

21 THE COMMISSIONER: Well, I want you to  
22 finish your cross-examination either now or some other  
23 time.

24 MR. HUNT: Yes, well, I appreciate that.  
25 I know that at 3:15 we were going to reassess it and  
we are now seven minutes away.





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THE COMMISSIONER: That's right.

MR. HUNT: So, I just wanted you to know I was still thinking of that.

THE COMMISSIONER: Okay.

MR. HUNT: Q. All right. The conduct or the incidents that occurred on the ward between June 30th and March 22nd, we have heard from a number of witnesses, were tremendously stressful and upsetting for everyone concerned, would you agree with that?

A. Yes.

Q. And after March 22nd when Justin Cook died we have also heard and seen that there were no more deaths of this nature that were suspicious or unaccounted for. Do you agree with that?

A. Yes, I agree with what you are saying.

Q. But the incident of strange events relating to Ward 4A and 4B and to people involved with the Trayner team did not end on March 22nd, did it?

A. I'm unsure what you mean by strange events?

Q. Am I correct that after March 22nd there were a number of strange distressing events that happened in connection with 4A/4B and members of





1  
2 the Trayner team?

3 A. Yes.

4 Q. And you yourself were involved  
5 in some of these events?

6 A. Yes.

7 Q. And the events took the form  
8 as I understand it, of threatening phone calls,  
9 threatening markings on personal property and the  
10 addition of a heart drug to the food of some of the  
11 nurses?

12 A. Yes.  
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1  
2 Q. And these events took place,  
3 as I understand it, for about a one-month period or  
4 perhaps a month and a half, beginning late in the month  
5 of August of 1981 and continuing on to early October  
6 of the same year?

7 A. I don't recall the length of  
8 time.

9 Q. All right. Would it be fair  
10 to say that the events that took place in that  
11 period of time were such that they caused additional  
12 stress --

13 A. Yes.

14 Q. -- concern and indeed terror --

15 A. Yes.

16 Q. -- to the nurses involved on  
17 4A/4B and on the Trayner team?

18 A. Yes.

19 Q. And would you agree with me  
20 that the behaviour shown by those events can only  
21 be described as bizarre?

22 A. Yes.

23 Q. Would you agree with me that  
24 the behaviour shown by those events is behaviour that  
25 you would expect from someone who is seriously  
mentally unbalanced?







1  
2 A. I am neither a psychologist  
3 nor a psychiatrist.

4 Q. I am not asking you for an  
5 expert opinion. Just as a person who was there and  
6 who was involved and saw what was happening. Did you  
7 not have concern that there was somebody who was  
8 mentally unstable involved in those events?

9 THE COMMISSIONER: I'm sorry. Yes,  
10 Miss McIntyre?

11 MS. McINTYRE: Mr. Commissioner, I  
12 think Mr. Hunt should accept the witness' answer that  
13 she is not an expert and I would suggest that she not  
14 answer this question. She does not have the expertise --

15 THE COMMISSIONER: Well, I think --

16 MS. McINTYRE: -- to say that someone  
17 is mentally disturbed.

18 THE COMMISSIONER: She can give whatever  
19 answer she likes. She can say I don't know and I  
20 don't want to express an opinion, but we all have views  
21 even though we are not qualified as to whether  
22 behaviour is bizarre. So I don't find the question  
23 improper.

24 MS. McINTYRE: Well, Mr. Commissioner,  
25 she answered that question and the next question was  
whether or not the person would have been mentally





1  
2 disturbed and she said she wasn't a psychiatrist or  
3 psychologist.

4 THE COMMISSIONER: Well, that's fine.  
5 And all that he is doing is probing that. But we  
6 all, whether we should or not, we all - and perhaps  
7 all of us except Mrs. Radojewski, I don't know, but  
8 the rest of us are always saying somebody is behaving  
9 in a crazy manner, and not just joking. We say we  
10 think someone is unbalanced. And we do that without  
11 any qualifications whatsoever. Maybe I am just  
12 speaking for myself, I don't know.

13 Anyway I will allow the question. I  
14 don't know what the answer will be.

15 MR. HUNT: Q. I am just asking for  
16 your opinion just as an ordinary person.

17 Did you not have some concern that the  
18 person behind these events that took place in that  
19 period of time was mentally unstable?

20 A. I suppose I have trouble with  
21 the term "mentally unstable". Weird is about the  
22 best word.

23 Q. Weird? All right. And the  
24 events were of such a nature I take it that they were  
25 certainly common knowledge to everybody involved on  
4A and 4B?





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A. Yes.

Q. To a certain extent they disrupted the operation of the ward? I don't mean in a sense that it endangered any patients or the care that was delivered wasn't adequate. I am just saying that it disrupted the normal operation of the wards in the sense that there was additional security put on at a certain point in time.

A. It created more stress.

Q. And was it your understanding that certain of these events occurred prior to you yourself being involved?

A. Yes.

Q. And was it your understanding that the events began with threatening phone calls to the home of Nurse Sui Scott?

A. I can't recall today if that was what they started with.

Q. Are you able to recall whether they began with threatening phone calls?

A. I don't recall if it was phone calls or markings first.

Q. All right.

A. I just don't recall for sure.

Q. You recall that there were





1  
2 threatening phone calls prior to the events that you  
3 were involved with occurring?

4 A. Yes.

5 Q. Is it your understanding that  
6 the phone calls that were involved were from an  
7 unidentified female?

8 A. The phone calls that -- it is  
9 my understanding that the phone calls that Mrs. Scott  
10 received - I am unsure. I know that the one I re-  
11 ceived was a female.

12 Q. All right. We will deal with  
13 that. Was it your understanding then that the  
14 incidents that preceded yours in terms of phone calls  
15 involved threatening remarks directed at both Phyllis  
16 Trayner and Nurse Sui Scott?

17 A. Yes.

18 Q. You also mentioned that there  
19 were incidents involving markings being put on  
20 property of others prior to yourself being involved  
21 as a recipient of a phone call?

22 A. Yes.

23 Q. Was it your understanding that  
24 these incidents involved red 'Xs' being put in lip-  
25 stick on the automobile of Phyllis Trayner and on the  
locker doors of Sui Scott and Phyllis Trayner?







1  
2 A. At the beginning of your  
3 question I am unsure which came first. It sort of  
4 melted together in my mind.

5 Q. All right.

6 A. But those were the markings,  
7 yes.

8 Q. And in addition markings  
9 in the form of 'Xs' on the apartment door and apart-  
ment hallway of Phyllis Trayner?

10 A. I remember that coming up,  
11 yes.

12 Q. Do you recall approximately  
13 when you yourself became involved in these incidents?

14 Perhaps I could save time. I will  
15 suggest to you it was on September 1st of 1981. Does  
that accord with your recollection?

16 A. Of the phone call?

17 Q. Yes.

18 A. It could very well be.

19 Q. All right.

20 MR. BROWN: I hate to interrupt my  
21 friend, and I certainly don't want to. I believe it  
22 was August 30th, and I think in order to avoid any  
23 confusion as to date and time there was filed at the  
24 preliminary inquiry a chronology of all of these events.  
25





1  
2 That is marked as Exhibit 76, which I think is probably  
3 in Volume 32B.

4 MR. HUNT: My friend is quite correct.  
5 It was August 30th and it was September 1st reported  
6 to the police, on the following day.

7 THE COMMISSIONER: Yes.

8 MR. HUNT: It was August 30th.

9 Q. I take it that accords with  
10 your recollection of approximately when it occurred?

11 A. I know it was a Sunday evening.

12 THE COMMISSIONER: Sunday evening did  
13 you say?

14 THE WITNESS: Yes.

15 MR. HUNT: Q. Now what happened first  
16 so far as you were concerned?

17 THE COMMISSIONER: You mean affecting  
18 her?

19 MR. HUNT: Yes.

20 A. I'm sorry, I don't -- I'm  
21 sorry, I am aware of the time as well but I don't  
22 understand the question.

23 Q. Well, what was the first thing  
24 that happened to you on that Sunday night?

25 A. On that Sunday night?

Q. Yes.





1  
2  
3 A. There were two phone calls  
4 at my home where there was no one speaking at the  
5 other end of the line, and then there was a third  
6 phone call.

7 Q. All right. Two phone calls  
8 that occurred when no one was speaking, Did someone  
9 hang up immediately?

10 A. It wasn't immediate, but  
11 someone did, yes. There was the sound of a receiver  
12 hanging up.

13 Q. All right. And you say then  
14 there was a third phone call. I take it on this  
15 occasion someone spoke?

16 A. Yes.

17 Q. Was it a male or female?

18 A. My recollection was and is  
19 that it was a female voice.

20 Q. What did the voice say?

21 A. They said "Trayner dies first  
22 then Scott".

23 Q. "Trayner dies first then  
24 Scott"?

25 A. Yes.

Q. And you took that to be





reference to Phyllis Trayner and Sui Scott?

A. Yes.

Q. And I imagine that phone call was very distressing to you?

A. Yes.

Q. At that point in time I take it you would have recognized that as being similar to other events that you had already heard about?

A. It seemed to be similar to what I was hearing about, yes.

Q. And you reported that event to the police on the following day?

A. I remember trying to get hold of someone from the police that evening. I don't remember if I was successful.

Q. All right. Now can you describe the female voice that you heard?

A. It seemed that of a small person and it seemed as if it could have been muffled.

Q. It sounded muffled and it seemed to be that of a small person. What made you think it was muffled?

THE COMMISSIONER: I'm sorry, when you say a small person, this is silly, but I suppose you mean by that a young person? Is that what you mean?







1  
2 How can a voice sound like a small person? Do you  
3 mean a young person?

4 THE WITNESS: What I interpreted in  
5 my own mind it was someone who had a very soft voice  
6 and, yes, as opposed to someone older. It was a young  
7 type voice.

8 MR. HUNT: Q. And by muffled, what  
9 do you mean when you say that you thought it sounded  
10 muffled?

11 A. It wasn't a really clear,  
12 distinct voice. My husband heard it with me, and that  
13 was his impression as well.

14 Q. When you reported it to the  
15 police the next day, did you describe for them the  
16 voice?

17 A. I was asked to describe the  
18 voice, yes.

19 Q. Did you describe it?

20 A. Yes, as best I could.

21 Q. And did you offer any opinion  
22 to the police as to whose voice it might have been?

23 A. I was asked to offer an  
24 opinion and I was -- I also can remember saying that  
25 I wouldn't swear to this but it was a voice similar  
to that of Susan.





Radojewski  
cr.ex. (Hunt)

2 Q. Susan Nelles?

3 A. Yes.

4 MR. HUNT: I was going to move to  
5 the next incident.

6 THE COMMISSIONER: Yes. I would just  
7 like to discuss life with you and Mr. Percival at  
8 the moment.

9 First of all, how long do you think  
10 you will be?

11 MR. HUNT: In total?

12 THE COMMISSIONER: From now on, yes.

13 MR. HUNT: I would think in total  
14 probably half an hour.

15 THE COMMISSIONER: That will take us  
16 if we take 20 minutes, that will take us until after  
17 four o'clock.

18 And you thought you would be three-  
19 quarters of an hour?

20 MR. PERCIVAL: I would think so, yes.

21 THE COMMISSIONER: Well, I will  
22 certainly stick it until you are finished, there is  
23 no question about that. The only thing is I was  
24 trying to move Mr. Hunt's hard heart to stand down to  
25 you, that's all, and I don't know whether I can do that  
or not.





SE12

Do you want to think about that?

MR. HUNT: I will think about it over the break and discuss it with Mr. Percival. I have, when I say half an hour, I could finish this area in less time.

THE COMMISSIONER: Well, perhaps you could finish -- perhaps that would be the solution, if you finish this area and then we could reserve the rest of it until Monday and let Mr. Percival get on. Anyway, you think about that and discuss it and we will take 20 minutes.

--- recess.





Radojewski  
cr. ex. (Hunt)

1  
2 ---Upon commencing.

3 THE COMMISSIONER: Yes, Mr. Hunt.

4 MR. HUNT: I think we have worked out  
5 a compromise. I am going to finish this area which  
6 I could do in about 15 minutes and then Mr. Percival  
7 can take over and complete his today and I will  
8 accept your invitation to finish on another day.

9 THE COMMISSIONER: Come back on  
10 Monday.

11 MR. HUNT: Yes, all right.

12 THE COMMISSIONER: All right.

13 MR. HUNT: Q. Mrs. Radojewski,  
14 the next matter I would like to deal with is the  
15 second incident that you became involved in, and by  
16 this I am referring to the time when you went down  
17 to the hospital yourself in the middle of the night  
18 as a result of a phone call I believe.

19 A. Yes.

20 Q. And do you recall approximately  
21 when that happened in relation to the phone calls  
22 that you received?

23 A. I remember it being the fall.

24 Q. Was it before or after?

25 A. Oh, I'm sorry, after the phone  
call.







1  
2 Q. All right. If I suggest to you  
3 that it was on the evening of September 25th and into  
4 the morning of September 26th of 1981 does that  
5 accord with your recollection, that would be about  
6 three weeks or a little more than three weeks after  
7 the phone call to yourself?

8 A. Can I ask you if that was a  
9 Thursday, the 25th, I'm sorry, I remember better by  
10 days of the week.

11 Q. You can certainly ask, I don't  
12 think I can help you.

13 THE COMMISSIONER: The 30th was  
14 a Sunday, at least I think it was a Sunday. We did  
15 not have a dispute with respect to that, but that would  
16 make it the 6th, the 5th is a Sunday, isn't it?  
17 No, it is the 6th, is that right?

18 MR. HUNT: Yes, the 25th was a  
19 Thursday, the 26th was a Friday, according to my  
20 calculations.

21 THE COMMISSIONER: The 27th would be  
22 a Friday so this would be, I don't know, I give up,  
23 I thought it was a Wednesday.

24 MR. HUNT: I don't think it is really  
25 that critical.

THE COMMISSIONER: It does matter because





1  
2 one thing she does know is that it was a Thursday,  
3 would it be around about three days later?

4 THE WITNESS: Yes.

5 Q. Am I correct that you received  
6 a phone call at your home very early in the morning  
7 advising you that something very urgent required you  
8 to come down to the hospital?

9 A. Yes.

10 Q. And at that time you were advised  
11 two of the nurses, that being Phyllis Trayner and  
12 Sui Scott, when having their meal at approximately  
13 2 o'clock in the morning, found heart pills mixed  
14 in with their food?

15 A. There were pills in their food,  
16 yes.

17 Q. And on hearing that information  
18 you immediately went down to the hospital?

19 A. Yes.

20 Q. And what did you find when you  
21 arrived there?

22 MS. FOSTER: Mr. Commissioner, I am  
23 not sure where my friend is going with this line of  
24 questioning, but it does not seem to me it is relevant  
25 to Phase 1.

THE COMMISSIONER: Well, it may have





something to do with the cause of death, that I think is the purpose of it. Why does it not have something to do with the cause of death.

MS. FOSTER: It would have to do with the threats that occurred long after the deaths started.

THE COMMISSIONER: Well, that's true. You see, if this were a trial to find out what the cause of death was, would this not be relevant, the fact that there were threats made? You see, the prominent people in this story are obviously members of the Trayner team. The two members of that team had some pills, anything strange in their food shortly after the event, is that not relevant to the cause of death? I don't know what it proves, but it certainly is relevant and everybody has a right to make an argument as to what it stands for. That is all I am saying.

Now, it may also have a good deal to do with Phase 2. In my ruling I have had to make it that we are dealing with Phase 1, now we must have everything that has anything to do with Phase 1. You just asked me the question, and I answered it the best I can, perhaps Mr. Hunt can answer it better, I don't know.





1  
2 MR. HUNT: No, I accept that, sir.

3 MS. FOSTER: Certainly he asked her  
4 about the one incident that involved her and I can't  
5 see any connection there with --

6 THE COMMISSIONER: I know, but this is  
7 one that she was present at the time, not at the time,  
8 not at the time they opened the food or started the  
9 food, but after, at some point later. Well, there  
10 may come a time of course when it is clearly only  
11 Phase 2, but at the moment it seems to me to be Phase  
12 1 as well, and I can't help it if it is both, there  
13 is nothing I can do to keep it out. We will certainly  
14 be very concerned about any speculation as to who put  
15 the pills there. Unless there is some basis for it,  
16 as there obviously was a basis for the other previous  
17 incidents, and I am talking about the telephone  
18 calls. Now --

19 MR. HUNT: Yes, thank you, Mr.  
20 Commissioner.

21 Q. Was it your understanding on  
22 arriving there that the two nurses in question,  
23 Phyllis Trayner and Sui Scott, had taken their  
24 lunches from the refrigerator on 4A and 4B on the  
25 evening prior to sitting down to eat their meal?

A. I don't recall if both of them







1  
2 took theirs from the refrigerator, I know one was  
3 a salad that was in the refrigerator.

4 The other was soup, and I don't  
5 know that that would be in the refrigerator.

6 Q. In any event they were both  
7 eating their lunches at the eating area at the  
8 nurses' station at 4A/4B?

9 A. Yes.

10 Q. And during the course of that,  
11 and I appreciate you were not there when this drug  
12 was found in the food, and we will hear from the  
13 people in due course who were involved; but your  
14 understanding was that during the course of eating  
15 their meal it was discovered in both meals certain  
16 pink colored pills.

17 A. Pink/orange colored pills.

18 Q. And those pills were analyzed  
19 and later found to be the drug propranolol?

20 A. As I recall, yes.

21 Q. And that is a heart drug that is  
22 used to affect the conduction system within the heart?

23 A. Yes.

24 Q. And when you arrived were you  
25 able to observe any of the pills in the food?

A. Yes. I remember seeing the





1  
2 bowl of salad with some of the pills appearing on the  
3 top, and the soup seemed to have traces of pills that  
4 were melting.

5 Q. The pills in the soup had  
6 obviously dissolved.

7 A. They were in the process of  
8 dissolving.

9 Q. And in the salad they were still  
10 present?

11 A. Yes.

12 Q. Did you then attend at the  
13 Toronto General Hospital with Nurse Trayner and Nurse  
14 Scott for the purpose of a medical examination of  
15 both of them?

16 A. Yes, I did.

17 Q. And was it your information  
18 as to whether or not the medical examination  
19 conducted on them revealed that either had ingested  
20 propranolol?

21 A. I don't recall for sure, I  
22 remember the treatment they got, I can't recall much  
23 else.

24 Q. We will deal with the individuals  
25 involved with that later. I take it that the discovery  
of this was a very shocking thing for you.





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A. Yes.

3

Q. And indeed a shock for everyone

4

connected with the ward.

5

A. Yes.

6

Q. Would I be correct in suggest-

7

ing to you that one thought that struck you at that

8

time was that whoever put those pills in the food

9

must have been someone who was connected with Ward

10

4A/4B?

11

THE COMMISSIONER: It may follow

automatically, but it doesn't quite to me, yet.

12

MR. HUNT: Perhaps I can establish the

basis for it.

13

THE COMMISSIONER: Yes.

14

Q. We have two nurses, at least

15

one of whom had their dinner in the fridge on

16

Ward 4A/4B, they both were sitting down to eat their

17

dinner on the ward in the presence of each other and

18

possibly other nurses from the ward.

19

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DM.jc  
2-FF  
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1  
2 One of the dishes that was involved was a bowl of  
3 liquid soup, and during the course of - in which you  
4 have already indicated the pills were dissolving at  
5 a point in time when you saw them. It was during  
6 the course of eating this dinner that the pills were  
7 discovered both in the salad and in the soup.

8 My question is, based on all of that  
9 and the circumstances surrounding the finding of the  
10 pills, did it not cross your mind at that point in  
11 time that whoever was responsible for putting the  
12 heart drug into the food must be somebody connected  
13 with the ward?

14 A I don't remember that I put it  
15 down to someone connected with the ward because  
16 there is access to the ward by many people.

17 Q I take it you were thrown back  
18 into the same dilemma that we have been facing back  
19 in the period from June 1980 through to March 1981,  
20 that is, who has access to the ward at various points  
21 in time?

22 A Similar, yes.

23 THE COMMISSIONER: Well, did the  
24 thought cross your mind, really I think the question,  
25 to put it in a way that would be satisfactory to you,  
but please don't automatically say yes to this. Did







1  
2 the thought cross your mind that it must have been  
3 someone who had access to the ward who had done it?  
4 That is the pills would have to have been put in the  
5 food on the ward itself. Did that cross your mind,  
6 and if it didn't just say no. There are three  
7 possible answers, yes; no; and I don't know; and  
8 any one of them is perfectly acceptable.

9 THE WITNESS: I don't recall that that  
10 thought crossed my mind at that time.

11 MR. HUNT: Q Did that thought, without  
12 getting in any deeper, did that thought cross your  
13 mind at some point in time?

14 A Yes.

15 Q Now, would you agree with me  
16 that insofar as all of these events up to that point  
17 in time were concerned, and that is the threatening  
18 phone calls and the threatening marks on personal  
19 property, that this one was by far the most serious?

20 A Yes.

21 Q This one posed a direct threat  
22 to the health and safety of the people involved?

23 A Yes.

24 Q And suggested at least that  
25 there was reason to be concerned about the health  
and safety of those people, and indeed perhaps those  
on the ward?





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A. We were concerned as well about the health and safety of our patients too.

Q. I am not suggesting for a moment that you were not, but these events didn't involve the patients in any way, did they?

A. No.

Q. These events primarily involved Sui Scott and Phyllis Trayner?

A. Yes.

Q. And I take it for the period when they were occurring from August through until some time in October, there was considerable concern about the safety of Sui Scott and Phyllis Trayner?

A. Yes.

Q. And there was considerable attention attracted to their well-being during that period of time by virtue of the events?

A. Yes.

Q. Did the events as I have suggested to you, according to your recollection, cease insofar as the Ward 4A/4B is concerned in early October of 1981?

A. I don't recall for sure.

Q. You do recall at some point in time they did stop?





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Q And are you able to say approximately how long after this incident when you went to the Hospital at two in the morning that that occurred; a long time, a short time?

A It may have been a couple of months, to give it some time frame, it wasn't a very long time and it wasn't a very short time.

Q Well, did any of the parties involved, and by that I mean Phyllis Trayner and Sui Scott, were either of them, or both of them transferred off of their position on Ward 4A and 4B at any time?

A Yes, they were.

Q Can you recall whether it was one or both of them?

A Both of them were.

Q Do you have any recollection as to when that was?

A I can remember it was some time before Christmas because it involved sorting out at Christmastime and rearranging the schedule.

Q Then let me ask you, after they were transferred off the ward, do you recall any events of this nature happening?

A There was nothing on 4A/B.





2-FF

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Q. After that?

3

A. That's right.

4

Q. So all of the events so far as it related to Sui Scott and Phyllis Trayner occurred prior to them being transferred off the ward?

6

A. Yes.

7

Q. To what ward was Sui Scott transferred?

8

9

A. Neurosurgical, I am sorry, Ward 5G.

10

11

Q. Do you recall what ward Phyllis Trayner was transferred to?

12

A. The Burn Unit on 8E.

13

THE COMMISSIONER: I am sorry?

14

THE WITNESS: 8E Burn and Plastic Unit.

15

MR. HUNT: Q. Are you aware as to whether or not any other incident occurred on either the 5G, to which Sui Scott was transferred, or 8E to which Phyllis Trayner was transferred after they went there?

19

20

A. I don't know.

21

MR. HUNT: I think that is an appropriate spot to leave this.

22

THE COMMISSIONER: All right, thank you.

23

Mr. Percival?

24

25







2-FF

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MR. HUNT: Thank you, Mr. Commissioner,  
for your indulgence, and my friend as well.

THE COMMISSIONER: Not at all, but we  
will hear from you again, I take it you are not  
finished and we will hear from you again on Monday?

MR. HUNT: No, I am not.

CROSS-EXAMINATION BY MR. PERCIVAL:

Q Mrs. Radojewski, my name is  
Percival and I appear on behalf of The Metropolitan  
Toronto Police. I want to deal if I may and perhaps  
Mr. Elliot can give it to you, Exhibit 32A, Tab 17,  
which are your notes.

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BM/PS

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MR. PERCIVAL: Mr. Commissioner, may I premise my question, it is not going into the contents of the notes, it is trying to establish when they were prepared.

THE COMMISSIONER: Yes, all right.

MR. PERCIVAL: And I want that to be clear before I commence this.

Q. As I recall your evidence on Wednesday, Mrs. Radojewski, your recollection is that the first two pages were prepared at some time, the first ten pages and then three more pages seemed to be all prepared at the same time.

A. Yes.

Q. Let's deal if I may with the ten numbered pages. Do you agree with me that, and I'm sorry, I think that you indicated that it was your belief that they were made after Susan's arrest but certainly before the end of March. I just want to be certain as to what your evidence is up until this point in time.

A. Yes.

Q. All right. If that be so, if I look at page 10, the numbered page 10, that deals with matters that occurred following the arrest of Susan Nelles. So, that would seem to tie in with your





1  
2  
3 recollection that it would have to be after the  
4 arrest of March 25th.

5 A. Yes.

GG-2 6 Q. And I would like to know if you  
7 prepared these ten pages as a compendium based upon  
8 many other notes that you then transposed to this  
9 and threw the other notes away.

10 A. No.

11 Q. All right. Do I take it then  
12 that you sat down on one occasion and from your  
13 memory then wrote these ten pages out without the  
14 aid of any other documentation?

15 A. I don't know that it was at  
16 one sitting of, say, several hours, but it was within  
17 a couple of days.

18 Q. Those notes, those first ten  
19 pages of notes first became the subject matter of  
20 comment I suggest to you at a time when you were being  
21 examined and cross-examined back on January of 1982,  
22 is that correct?

23 A. Yes.

24 Q. And I think that the sequence was  
25 that you were being asked certain questions, you said,  
26 well, I've got some notes I think and you went and  
27 got them from your briefcase.





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A. Yes.

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Q. And that was in fact on or about  
January 18th or 19th of 1982; is that your recollec-  
tion?

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A. It was at the preliminary hearing,  
yes.

7

8

Q. Thank you. And at the bottom -  
have you got the transcript of Volume 3 before you?

9

A. I'm sorry, I have Volume 1.

10

Q. 485 and 486, bottom of the page.

11

MS. MCINTYRE: Do you not have that?

12

THE WITNESS: No, I just have Volume  
1.

13

14

MR. PERCIVAL: Q. I will read it verbatim  
and then there is no changes and this is where it  
came up. 485, line 25:

15

16

"Q. Did you talk to Miss Nelles at  
any other time with respect to the death  
of Baby Pacsai?

18

19

A. Hm-mm. Yes, I did.

20

Q. When was that?

21

22

A. It was some time between the  
Monday, was it, March 23rd, and the  
Wednesday morning of that week.

23

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Q. Where did that conversation

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Radojewski  
cr. ex. (Percival)

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take place?

A. Over the telephone.

Q. And how did that conversation  
come about?

A. I was calling those team members.

Q. You were calling what?

A. I was calling those team  
members and asking them, well, more  
or less telling them that they were  
not to come into work at their scheduled  
time.

MR. WILEY: Why was that, why were you  
giving them the message?

A. I was told by the administra-  
tion of the hospital.

Q. I see."

And then you answered:

"A. Can I use my notes?

Q. Yes, certainly.

COURT: Are you going to refer to  
your notes now?

A. If I can.

Q. When did you make them?

A. After the conversations that  
I had while this was going on the week





of March 23rd.

Q. This is a conversation about  
March 23rd?

A. About that time.

Q. When did you make the notes,  
either exactly or approximately after the  
conversation was held?

A. Shortly after on the same day.

Q. Can you pinpoint the time, the  
lapse of time any more particularly than  
that?

MR. COOPER: I have no objection.

THE WITNESS: It would be later in the  
evening."

Now, do you recall being asked those questions and  
giving those answers?

A. Yes.

Q. And the conversation that you  
were talking about was the call that you were going  
to make, I suggest, on Tuesday evening, on Tuesday  
evening, March 24th as opposed to Monday evening,  
March 23rd to the members of the team to tell them  
not to come in the following day.

Perhaps I will put it this way. Mrs.  
Radojewski, the Trayner team was supposed to work





1  
2 long nights on the Monday night -- I'm sorry, the  
3 Sunday night, 7:00 to 7:00 the next morning, Monday  
4 morning.

5 A. Yes.

6 Q. And I am going to get to that,  
7 but you had called them on Sunday during the day to  
8 tell them not to come in?

9 A. Yes.

10 Q. The second call to which that  
11 passage I have just referred to alludes to is, the  
12 second call that you had to make to the same Trayner  
13 team telling them not to come in on the Wednesday  
14 morning.

15 A. I can't recall right now whether  
16 it was Wednesday morning or Wednesday evening.

17 Q. But it was Wednesday in any event?

18 A. Yes.

19 Q. All right.

20 THE COMMISSIONER: But you did  
21 make such a call, did you? I hadn't heard about this  
22 call, but you did call them?

23 MR. PERCIVAL: This is a call on the  
24 Tuesday, yes, Mr. Commissioner, you have heard about  
25 it, on the Tuesday.

THE COMMISSIONER: Have we heard that,





1  
2 I'm sorry, I missed it.

3 MR. PERCIVAL: Q. On a Tuesday after-  
4 noon or Tuesday evening you called the nursing team,  
5 told them not to come in a second time?

6 A. Yes.

7 Q. All right. What I am putting to  
8 you is this, that it seems to me, and that is what  
9 you are being asked about Nurse Nelles, does this  
10 seem to refresh your recollection that it was on the  
11 night of Tuesday, March 24th that you prepared these  
12 notes? As you have said, it would be later in the  
evening.

13 A. I don't recall but I did prepare  
14 them on that Tuesday evening.

15 Q. So, you can't explain that any  
16 more than what you have?

17 A. That's right.

18 THE COMMISSIONER: I'm sorry. Yes,  
19 Ms. McIntyre?

20 MS. MCINTYRE: Yes, Mr. Commissioner.  
21 I think to be fair to the witness there was cross-  
22 examination on this point at the preliminary inquiry  
23 and it is found at page 590 and 591.

24 THE COMMISSIONER: Can you just tell  
25 me what it says?







MS. McINTYRE: At that point the witness has clarified that she can't remember exactly when the notes was taken but it was done after Susan's arrest, shortly after Susan's arrest. It is on page 591.

THE COMMISSIONER: 591?

MS. McINTYRE: Yes. Where it says:

"I just want to ask you something.

You say that these notes preceded your interview with the police..."

MR. PERCIVAL: No, with respect, Ms. McIntyre, that refers to the first two pages on this document, it is not the numbered ones. I am going to get to that, Mr. Commissioner.

MS. McINTYRE: Well, the notes were being treated as a group at that point but it is clear that she said they are after the arrest.

THE COMMISSIONER: But she told us that, I don't know, would you like to go back, but I think she did say right here, she said...

MR. PERCIVAL: They were made after Susan's arrest and before the end of March. Clearly she had said that in these proceedings.

THE COMMISSIONER: She has said that here, I think.





1  
2 MR. PERCIVAL: That is why I am asking  
3 whether or not does her previous evidence under  
4 oath cause her to question that and whether or  
5 not she made all ten pages at once.

6 Q. You see, Mrs. Radojewski, if  
7 you did some of it some time, that would take us  
8 to March 24th, it would take you almost to the bottom  
9 of page 7 in your notes, and then I can understand  
10 why you would start Wednesday, March 25th, two-thirds  
11 of the way down on page 7 and carry forward.

12 Can you assist me?

13 A. I'm sorry, I don't know what  
14 you're asking me.

15 Q. Well, I am asking you the evidence  
16 that you gave under oath on a previous occasion, does  
17 it cause you to doubt whether you made these ten  
18 pages all at one sitting as opposed to perhaps in  
19 two sittings, 1 to 7 and then starting up after the  
20 arrest of Susan Nelles?

21 A. It's my recollection that I was  
22 making these after Susan's arrest.

23 Q. All right. Now, the first two  
24 pages then -- I will leave that -- the first two pages  
25 of Tab 17 deal with the question of Susan Nelles and  
where she was on the team and whether she was on shift,





1  
2 off shift and whether she was with the team or not;  
3 am I correct on that?

4 A. Yes.

5 Q. And do I take it that that was  
6 made after the police interview?

7 A. There were several police  
8 interviews.

9 Q. All right. But no one asked you  
10 to make these particular notes, these two pages?

11 A. No.

12 Q. And they were made for your own  
13 purposes to lay it out to be of interest to you when Ms.  
14 Nelles was or was not in the team setup, is  
15 that correct?

16 A. Yes.

17 Q. Thank you. You were asked  
18 something I believe earlier this week about the  
19 ability or inability of Susan Nelles. Did she have  
20 certain aspirations to be a team leader?

21 A. She was ambitious, yes.

22 Q. All right. And at one point in  
23 time I gather she was disappointed because someone  
24 else was chosen to be a team leader over herself.

25 A. I did not learn that from Susan  
herself.





1  
2 Q. I understand. But you heard it  
3 from other members of the team?

4 A. Yes.

5 Q. That she had said it to them.

6 A. I assume she did, yes.

7 Q. All right. In fact, that is  
8 reflected in the notes that you have indicated  
9 here on the third page, I believe -- I am sorry, some-  
10 where in these notes.

11 THE COMMISSIONER: Second page.

12 MR. PERCIVAL: Second page, thank you.

13 THE COMMISSIONER: But I'm not sure,  
14 this seems to be about Joan's promotion. Who is  
15 Joan?

16 MR. PERCIVAL: Q. Is that Joan  
17 McIntosh?

18 A. Yes.

19 Q. All right. And she was chosen  
20 to take the team leader course?

21 A. No, she was chosen to become  
22 a team leader.

23 Q. All right. And was that a choice  
24 you made?

25 A. Yes.

Q. And was the other possible choice







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Susan Nelles?

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A. No.

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Q. So, was she even in the running?

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A. Not at that particular time.

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Q All right. Do you have at this point in time any other notes or memoranda kept by you that has not now been produced?

A I have nothing left.

Q Thank you. Yesterday or the day before when you were being questioned by Miss Cronk relating to Allana Miller, Mrs. Radojewski, you kept looking down at something. You will forgive me for making this observation. I was wondering, were you looking down at some notes for the purposes of answering the questions of Miss Cronk?

A I have made, in preparation for coming here, I reviewed the charts of the children involved and I made some notations because I don't have very good powers of recall.

Q Do I take it that when you were being questioned then of the events involving the death of Allana Miller and your observations that was something that you had to look to to refresh your recollection, these notes that you personally made?

A No, I can recall the events from Allana Miller.

Q So, maybe I wasn't being very observant, you do not recall looking down when





1  
2 you were being questioned by Miss Cronk about that?

3 A. I looked down many times here.

4 Q. All right. I want to deal  
5 next with the meeting that you had with Diane Croswell  
6 and Dr. Fowler after the death of Kevin Pacsai. I  
7 think you have given that evidence in some detail  
8 about Dr. Fowler having come to you and come to  
9 Diane Croswell. What was Diane Croswell's position  
at that time?

10 A. She was the teaching team leader  
11 for Wards 4A and 4B at the time.

12 Q. And do you recall him going  
13 down with you to Pathology to look at it?

14 A. Yes.

15 Q. And do you recall going with  
16 Diane Croswell to look at it?

17 A. The three of us went together.

18 Q. And do I take it it was either  
19 his suggestion or yours and Diane's suggestion that  
20 somebody should contact the nurse who was in charge  
of Kevin Pacsai to warn them of the forthcoming  
inquest. Whose suggestion was that?

21 A. I don't recall exactly whose  
22 suggestion it was.

23 Q. All right. During the course  
24  
25





1  
2 of that discussion with Dr. Fowler and with Diane  
3 Croswell being present, did Dr. Fowler say to you,  
4 or ask you and Diane Croswell whether you knew of  
5 any nurse who was unbalanced?

6 A I don't recall that.

7 Q Well, this was brought up on an  
8 earlier occasion by cross-examination at the  
9 preliminary, Mr. Commissioner, the cross-examination  
10 of Diane Croswell, Volume 21, page 15, line 5. Line 4,  
11 and I want to quote this to you to see if it  
12 refreshes your recollection.  
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H/EMT/ko

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2 This is Diane Croswell being cross-  
3 examined by Mr. Cooper:

4 "Q. And he wanted you you said I  
5 think to find out which nurses had  
6 looked after Pacsai?

7 A. That is correct.

8 Q. And didn't he also say to you -  
9 didn't he also ask you at that time,  
10 Dr. Fowler that is, did he not ask  
11 you at the same time if you knew of  
12 a nurse who might have been  
unbalanced? Didn't he ask you that?

13 A. Yes, he did.

14 Q. And you told him you weren't  
15 aware of any nurse that might have  
16 been unbalanced?

17 A. That is correct."

18 Now does that refresh your recollection  
19 of anything Dr. Fowler may or may not have said at the  
20 time you went down to look at the Pacsai chart in  
pathology?

21 A. It is very possible. I have no  
22 reason to dispute Mrs. Croswell.

23 Q. All right.

24 A. I just don't recall the  
25





1  
HH 2 2 conversation.

3 Q. Do you equate the utilization  
4 of the adjective "unbalanced" with the utilization  
5 of the adjective "weird" because you used the  
6 terminology "weird" in response to Mr. Hunt's  
7 question this afternoon?

8 A. To me there is a distinction  
9 between weird and unbalanced.

10 Q. What do you think the word  
11 "unbalanced" means?

12 A. In the context that Mr. Hunt  
13 was asking me, if I can explain why I answered as  
14 such?

15 Q. No, but I want you to  
16 distinguish if you can - try to distinguish if you  
17 can what you understood the difference between  
18 "unbalanced" and "weird"?

19 MS. McINTYRE: Mr. Commissioner, I  
20 think the witness was trying to answer by explaining  
21 what she had meant by the term "weird" and she should  
22 be given the opportunity to explain that if that  
23 seems to be the question.

24 THE COMMISSIONER: Yes. Yes, I think  
25 that is reasonable.

You were talking about, when Mr. Hunt





1  
2 asked you the question and you preferred to use the  
3 about  
4 word "weird". It was / conduct, about the activity,  
5 was that not correct?

6 THE WITNESS: Yes. And in the context  
7 that Mr. Hunt was saying, when there is an event such  
8 as took place on the ward that that is a period of  
9 time when it brings out weird people and weird  
10 happenings, and it was meant in that context.

11 Mentally unbalanced implies a condition,  
12 to me, a condition, a state of mind where I think we  
13 are all guilty of some weird behaviour at some time.

14 MR. PERCIVAL: I will pass on to the  
15 next thing.

16 Q. After you then looked at the  
17 Pacsai chart you decided rather than Diane Croswell  
18 to phone Susan Nelles at home and obtained an unlisted  
19 number, did you?

20 A. I don't remember that it was  
21 unlisted.

22 Q. And at 5299 when you were  
23 questioned by Ms. Cronk you were asked as to Miss  
24 Nelles' response to the information you said:

25 "A. I recall that she was somewhat  
surprised that there was going to be  
an inquest, that she was thankful





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"that I called and she would sit down  
and write what she remembered about  
the patient."

Do you remember giving that evidence?

A. Yes.

Q. Now the question, all I get  
from that is that she was somewhat surprised. Did  
she seem angry that you called her at home on her  
holidays?

A. No. She was surprised I called  
her.

Q. Did she seem upset?

A. I don't really recall.

Q. Well, we heard evidence already  
in this Commission that when she came back onto the  
ward she was both angry and upset that you had called  
her.

Did she ever verbalize, to use your  
word, that to you when she came back to Toronto and  
before her arrest?

A. No.

Q. I want to deal next with the  
events in the utility room on the morning of Justin  
Cook's death, and I want to know, first of all, have  
you been present for a number of days at these hearings?







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A. I was present for half an hour  
on a Monday and a Tuesday a week ago.

Q. Who was giving evidence then?

A. Kathy Coulson.

Q. In any event dealing with what  
happened in the dirty utility room or the utility room  
on 4A/4B I think your evidence was that at 5385 and  
5386 you could not recall Susan Nelles being present  
in the dirty utility room?

A. She may have been. I didn't  
recall her.

Q. And you don't recall her saying,  
utilizing these words, "six out of seven ain't bad"?

A. I don't recall that, no.

Q. Are you aware of the fact that  
Bertha Bell recalls - recalled that particular thing  
being said by Susan Nelles? Have you been made aware  
of that?

A. I don't think so.

Q. Have you been made aware of the  
fact that Meredith Frise recalls that being said in  
your presence?

A. No.

Q. Are you aware of the fact that  
Liz Johnstone is aware of the fact of that being said





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on an even earlier occasion where having heard it from another source she had occasion to rebuke or speak to Susan Nelles about the utilizing of that terminology. Did you know that?

A. I don't recall that.

Q. Did you ever hear up until today or yesterday in these proceedings it being reported that in the dirty utility room on the morning of Sunday, March 22nd, that Susan Nelles is reported to have said that?

A. Yes.

Q. When did you first hear that?

A. I don't recall. It has been a long time.

Q. Do you agree with me it would be a rather shocking thing for any nurse to say after six or seven baby deaths had occurred in a row in a one week period?

THE COMMISSIONER: I am sorry. Mr. Brown?

MR. BROWN: Mr. Commissioner, I object to that. It is fair game to question a witness who was there, saw Susan Nelles, heard what Susan Nelles said, and then say what was your reaction. But to ask this witness who does not recall the event, did





1  
2 not see Susan Nelles, does not know the context in  
3 which the remark was made --

4 THE COMMISSIONER: I think there is  
5 something in that. I think much would depend upon  
6 the tone of voice.

7 MR. PERCIVAL: Oh, quite, Mr.  
8 Commissioner, but one of the things is if there was  
9 no evidence before you already about this I would  
10 understand my friend's concern, but there is abundant  
11 evidence, and I can't --

12 THE COMMISSIONER: But the evidence,  
13 it seems to me, that we have heard is that that was  
14 a frustrated voice or something of that nature.

15 MR. PERCIVAL: That is in the utility  
16 room.

17 THE COMMISSIONER: And people could  
18 say that sort of thing without it really being ...  
19 I don't know. Speaking for myself, and I suppose  
20 myself is moderately important in these proceedings,  
21 I don't take a great deal out of a statement that --

22 MR. PERCIVAL: You will forgive me  
23 if I don't dispute that.

24 THE COMMISSIONER: All right.

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MR. PERCIVAL: May I deal with the  
next matter.

Q. After that discussion in the dirty  
utility room, if I can use that expression, you  
carried on, did you not, and had coffee with Phyllis  
Trayner and Susan Nelles before they went off shift?

A. I don't recall that.

Q. Well, Volume 4 -- let me  
read to you what Phyllis Trayner has said under oath  
with respect to what happened after you had that  
conversation to see if it refreshes your recollection.

Page 836, line 12:

"A. We went down for coffee for  
breakfast. Sue, Susan Nelles, myself  
and Liz Radojewski, and I can't really  
remember what we talked about. We  
tried to get off the subject of what  
had happened. Liz was -- Liz Radojew-  
ski was going to find out why the  
digoxin was locked up and her comment  
at that point was 'we use it all the  
time'. She didn't feel we needed to  
lock it up at this point because we  
used it all the time and she was going  
to wait for a pink memo to come around







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telling her it was locked."

"Q. Pink memo?"

"A. Yes."

"Q. What's that?"

"A. It's a memo that comes out from the doctor that has ordered this digoxin or the Director of Nursing or the Director of the Hospital saying that now the digoxins will all be locked up. She was confused and bewildered as to why they were locking up digs."

"Q. Well, did anyone say anything as to why they were doing this?"

"A. No. There was no explanation given to us that night. We were just told it had to be locked up. Now there would be a memorandum coming around a little later explaining as to why they were being locked."

"Q. Yes."

"A. Just to double-sign and double-check as we always had."

"Q. Why was Liz concerned? Did she say why she was concerned about this





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digoxin being locked up?"

"A. Because she had no answer as to why they are being locked up and she is the head nurse of Cardiology."

"Q. Was there any discussion in the presence of Susan Nelles at that time or any other time about the digoxin and the effect it might be having on these babies?"

"A. No. We talked briefly about Baby Pacsai."

"Q. Baby Pacsai?"

"A. Yes, just briefly."

"Q. When did you discuss him?"

"A. That was on the Sunday morning at coffee with Liz."

"Q. March 21st or 22nd?"

"A. Okay."

"Q. Yes?"

"A. And Liz had just asked Susan if she had written down everything she had done that night for Baby Pacsai."

"Q. And what did Susan say?"

"A, Yes, she had."





HH3.5

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Q. Thank you.

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Now later that day you continued on in your work as a supervisor, and I want to get to the point where you received certain information from Mrs. Geiger; is that correct?

7

A. From Miss Geiger.

8

Q. Miss Geiger?

9

A. Yes.

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11

Q. And she instructed you I gather to call the nursing team that was supposed to be coming on and tell them not to come in?

12

A. Yes.

13

14

Q. And did you accept or question Miss Geiger's instructions about the reason why they were not to come in?

15

16

A. It would seem logical to me that I did. I just don't have any recollection of it.

17

18

Q. Did you think it was a good idea?

19

20

A. I wouldn't have questioned Miss Geiger's authority.

21

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Q. No, but did you think it was a good idea that they not come back in after having two deaths in a row?

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A. I don't know.





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Does that refresh your memory of that discussion at coffee with Susan Nelles and Phyllis Trayner after Justin Cook had died?

A. I don't recall that.

Q. Well, if Phyllis Trayner says that under oath, are you prepared to accept that was in fact a meeting that took place between the three of you and those matters were discussed?

A. I have no reason to dispute that.

Q. Thank you. It would seem to be based upon Phyllis Trayner's recollection of it that you were somewhat concerned about the digoxin being locked up, at least in the verbalization that you had with her.

Does that seem to also refresh your recollection as to your attitude that morning?

A. That helps to refresh it, yes.

Q. Because you say at 5395 earlier in this Commission, you said you don't recall whether you were concerned about the digoxin backup. Does this cause you to think that probably you were concerned?

A. Yes.







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Q. Your answer at 5399 earlier was that neither Mrs. Trayner nor Miss Nelles reacted adversely or negatively to your telephone call. Do you remember telling Miss Cronk that?

A. Yes.

Q. Did you ever hear from Nurse Trayner afterwards about how disturbed and angry she was and surprised to have received that phone call that night?

A. I don't recall.

MR. PERCIVAL: For the purpose of cross-reference, Mr. Commissioner, that is Volume 6, page 1220, and Volume 4, page 842.

THE COMMISSIONER: This in the preliminary inquiry?

MR. PERCIVAL: Yes.

THE COMMISSIONER: And the evidence of Phyllis Trayner, I take it?

MR. PERCIVAL: Yes. Thank you.

Q. Now, at this meeting with Mr. McGee and Mr. Wiley on December 1, 1981 that all counsel now have copies of - do you have it in front of you?

A. Yes, I do.





HH3.7

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Q. Do you remember telling them

3

this --

4

THE COMMISSIONER: Page?

5

MR. PERCIVAL: I don't know where it

6

is. I think it is page 3 at the bottom.

7

Q. "I don't remember if I spoke

8

to Susan on Sunday, March 22nd. The

9

team was (something) on Sunday.

10

THE COMMISSIONER: "removed", I think.

11

MR. PERCIVAL: "...removed on Sunday.

12

Mrs. Geiger told me to tell the

13

nurses not to come in. I phoned the

14

team, including Susan. I didn't know

15

what to tell them. I said something

16

about stress. I was afraid to think of

17

the real reason. I don't recall any

18

specific reaction from Susan. She

19

seemed resigned."

Do you recall telling Mr. McGee and  
Mr. Wiley that?

20

A. Something to that effect. I

21

don't know that those were my exact words.

22

Q. Well, I am intrigued by your

23

commentary, "I was afraid to think of the real

24

reason". I want to go to your state of mind on that

25





1

HH3.8

2

Sunday evening when you phoned them. What did you  
mean by that?

3

4

A. I don't know that I said that.

5

I haven't any recollection of actually saying that,  
and this was done December 1st.

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Q. Before you were cross-examined?

A. Yes, but after I had known that Susan was arrested.

Q. Well, at --

A. My feeling is that it was said in retrospect as Mr. Wiley and Mr. McGee were interviewing me.

Q. Well, that particular time when you were phoning those nurses was an afternoon when you were aware of a number of things, were you not? You were aware that the digoxin had been locked up; there were nursing supervisors on Ward 4A and 4B; they were monitoring each and every medication; there was transfers being made off of the ward and no one coming back on to it; the digoxin levels were being taken on every one of the remaining babies, were they not?

A. I don't remember that.

Q. You do now, don't you?

A. As you have said it, yes.

Q. Well all of those things, surely with the greatest of respect, Mrs. Radojewski, must have triggered some common connection between all of these events, unusual events and the death that had just occurred of Justin Cook, and the reason why this







II.2

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nursing team was taken off the next day, surely it  
must have been?

4

A. I don't have any recollection.

5

6

7

Q. Now, Mrs. Radojewski, I want  
to know - at pages 5416, Miss Cronk put a series of  
questions to you, and I want to quote your answer to  
one of them and I want to take it one step further.

8

MS. McINTYRE: What page?

9

MR. PERCIVAL: 5416.

10

11

12

13

Q. Do you remember the hypothesis  
that Miss Cronk started with about assuming that there  
were someone on that ward doing something to these  
babies and not wanting to be caught?

14

A. Yes.

15

16

17

18

19

20

21

22

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Q. 5416, line 13:

"If someone on those wards with a  
frequent access to the ward was intent  
upon deliberately interfering with  
a child, or children, and was intent  
upon administering an unauthorized  
medication and wanted to be as  
secretive as possible in the process,  
what in your judgment based on your  
knowledge of those wards will be the  
chances of their being detected by  
anyone else on the ward?





II.3

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"A. I suppose their chances would  
be very slim."

3

4

Do you recall being questioned and  
giving that answer?

5

6

A. Yes.

7

8

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12

13

Q. And I ask you to take a further  
extension of that, not just one baby, but a series  
of babies and assume a series of babies that died  
late at night, in the early morning hours, between  
2 and 4 o'clock; and a series of babies were being  
done by a perpetrator, what would be the class of  
person that would come within the words "someone on  
those wards"?

14

15

16

17

18

A. I am not sure I understand your  
question.

19

20

21

22

23

24

25

Q. Let me give it to you, I  
gather doctors are one of the classes of people that  
could be within the utilization of the word "someone"?

A. Yes.

Q. And I gather nurses are another?

A. Yes.

Q. And I gather registered nursing  
assistants are another?

A. Yes.

Q. Now which of those three are





II.4

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entitled to administer medication to these babies, on these wards, in March of 1981?

A. Registered nurses and doctors are entitled to administer medication to the babies.

Q. And if you look at a series of baby deaths, the pattern, more than one, and a person trying and a person deliberately interfering with the babies, which is more likely, the nurses or the doctors?

MS. McINTYRE: Can I just ask Mr. Percival to clarify how many there are in the series?

MR. PERCIVAL: How about four.

THE WITNESS: Would you repeat the first part, please?

MR. PERCIVAL: Q. Which is more likely in the two classes between doctors and nurses of someone on these wards?

A. I don't know.

Q. Well, when you talk about; when you say I suppose their chances would be very slim, would you agree with me that if there was more than one person that the chances of one acting as a perpetrator and one acting as a lookout, the chances of being detected are almost nil?

A. Yes.





II.5

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Q. Turning to the last matter, I want to deal with what happens when a baby dies on Wards 4A/B? I gather that the nurse who was assigned to the patient generally records the last nursing notes on the patient on his chart, is that correct?

A. Generally.

Q. And is that called a "sign off", I don't know the nursing parlance, what do you do when a patient dies and the nurse that is assigned signs the last nursing note, is that called a sign off?

A. I am not familiar with the term.

Q. What do you call it?

A. She writes a nursing note.

Q. All right. Have you ever up until March of 1981, ever written a nursing note recording the death of a baby?

A. The time frame up until March?

Q. Up until March of 1981.

A. More than likely I have, yes.

Q. Do I take it that the purpose of the last nursing note is to describe what happened, and also perhaps what went wrong?

A. It is for the nurse to document the observations she made of the child.

Q. As to what happened?







II.6

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A. Yes.

3

Q. Do I take it that it is, the

4

death of any patient, let alone a baby, is somewhat  
traumatic and stressful?

5

A. Yes, it is.

6

Q. And I gather that particularly

7

if the death is unexpected it is even more stressful

8

and more traumatic for the nurse who is signing these

9

last notes?

10

A. Yes.

11

Q. And do I take it also that

12

generally speaking it is not a function that a nurse

13

likes to perform? In other words, prepare the last

14

notes for this baby, or this patient in this Hospital,

15

you don't go out of your way to look for those?

16

A. I don't understand your question.

17

It is part of a nurse's duty that was caring for the

18

child.

19

MR. PERCIVAL: Well, Mr. Commissioner,

20

I have got something that may be of some assistance,

21

and as Mr. Scott did, I suppose we are all dying in

22

a sea of paper. I have a chart here that records, if

23

I may, the cardiac deaths in the time period in

24

question and reflects the identity of certain nurses,

25

and it does reflect the deaths of certain babies, and





II.7

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there are 35 named babies on that chart, Mr.

3

Commissioner. The 36 you remember is outside the

4

time frame, I believe it is Baby Woodcock, which was

5

on June the 30th. These were the cardiac deaths in

6

that time period, and you will note that there were

7

11 that occurred in the ICU and OR, only one of

8

which is really involved with us and that is Baby

9

Pacsai. That insofar as the nurses who signed the

10

last recorded nursing notes of these 35 babies is

11

recorded on the bottom and of those 35 11 of those

12

were signed by Nurse Susan Nelles; did you know that,

Mrs. Radojewski?

13

A. I don't know that I had time

14

to look at them like that, no.

15

Q. Did you ever have time to look

at them?

16

A. The charts were not made

17

available to me after the children had died.

18

Q. Did you ever think about it

19

after the event?

20

A. No.

21

Q. Phyllis Trayner had four, did

you know that that was so?

22

A. No.

23

MR. PERCIVAL: Mr. Commissioner, for

24

25





II.8

1  
2 your assistance, the pink is those that occurred in  
3 the year 1981; the yellow are those that occurred in  
4 the year 1980.

5 THE COMMISSIONER: I can't read those  
6 figures, I take it somewhere we get this 11 --

7 MR. PERCIVAL: The 11 is on the left-  
8 hand side, number of deaths.

9 THE COMMISSIONER: Yes. Is there some  
10 distinction between Susan Nelles and Phyllis Trayner,  
11 we don't get that from the chart.

12 MR. PERCIVAL: Yes, you do, 11 and 4.

13 THE COMMISSIONER: Oh, all right.

14 MR. PERCIVAL: Q. Are you aware whether  
15 you ever thought about the fact that of these many  
16 deaths that occurred in that nine-month period the  
17 person who seemed to be writing most of the dying,  
18 most of the last nurses' notes for the babies dying,  
19 seemed to be by coincidence Susan Nelles. Did you  
20 ever think of that?

21 MR. BROWN: I don't think it is a  
22 matter of coincidence, I think Miss Nelles was  
23 assigned to the baby, therefore Miss Nelles made the  
24 notes, I don't think there is any coincidence to that.

25 THE COMMISSIONER: Well, the one  
thing I would like to say, you said most of them were





II.9

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written, perhaps more than anybody else?

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MR. PERCIVAL: More than anybody else,  
yes, quite, Mr. Commissioner.

5

6

Q Did you ever think of that at  
any time up until now?

7

8

9

MS. McINTYRE: The witness has already  
said she didn't have any opportunity to examine the  
charts wherein that information would be obtained,  
so I think it is an unfair question.

10

11

12

13

THE COMMISSIONER: It is not an unfair  
question, all she has to do is say no, she didn't. I  
don't see any real difficulty about that if she  
didn't.

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MR. PERCIVAL: I would have thought  
so, Mr. Commissioner.







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II2.1  
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Q. And your answer?

3

A. I have forgotten the question,

4

I'm sorry.

5

Q. Did you ever think about the

6

fact that Susan Nelles seemed to be, more than any  
other nurse, on 4A/4B in that nine-month period,  
writing the last nurse's notes for babies who had  
died?

9

A. No.

10

MR. PERCIVAL: Thank you. No further

11

questions.

12

THE COMMISSIONER: All right, thank

13

you. Well, I think, I know everybody would like to  
go on but I think we will put it off until Monday.

14

Oh, you want to go on, do you?

15

MS. CRONK: No, Mr. Commissioner.

16

Could we get a time estimate from counsel for Monday?

17

THE COMMISSIONER: Yes, all right.

18

MR. PERCIVAL: I'm sorry, Mr.

19

Commissioner, could we have this marked as an exhibit?

20

THE COMMISSIONER: Yes, all right.

21

Exhibit 372.

22

MR. PERCIVAL: Thank you. I think

copies have been made for all other counsel.

23

THE COMMISSIONER: Yes, all right.

24

25





1  
II2.22 --- EXHIBIT NO. 372: Chart showing cardiac  
3 deaths referring to certain  
4 nurses on duty.

5 THE COMMISSIONER: Mr. Brown, have you  
6 any thoughts -- oh, I think you already told us.

7 MR. BROWN: 45 minutes.

8 THE COMMISSIONER: 45 minutes.

9 Miss Forster?

10 MS. FORSTER: 20 minutes to half an  
11 hour, sir.

12 MS. CRONK: I'm sorry, sir, I am not  
13 hearing them.

14 THE COMMISSIONER: I'm sorry, just a  
15 minute please. I wonder if we could just hold off  
16 just for a second.

17 Mr. Brown has said 45 minutes; Miss  
18 Forster said 30 minutes.

19 Miss Chown, have you any -- well,  
20 Mr. Roland, what about you?

21 MR. ROLAND: I don't know. I don't  
22 think I will be very long. I certainly don't think  
23 over half an hour.

24 THE COMMISSIONER: All right, 30  
25 minutes.

Miss Chown?

MS. CHOWN: No questions at this time.





1  
II2.3 2 THE COMMISSIONER: No questions.  
3 Miss Jackman?  
4 MS. JACKMAN: Mr. Commissioner, if I  
5 have any questions, it will be only a few minutes.  
6 THE COMMISSIONER: Mr. Olah?  
7 MS. JACKMAN: Excuse me. I have a  
8 problem on Monday. I am not exactly sure what time  
9 it is available. For part of the day I have to be  
10 in another court.  
11 THE COMMISSIONER: Certainly if you  
12 have no questions at all, you can do that just as well  
13 in the morning as in the afternoon. If you discover  
14 when you are available, could you not try to fit  
15 yourself in?  
16 MS. JACKMAN: Yes.  
17 THE COMMISSIONER: Mr. Olah?  
18 MR. OLAH: Unfortunately I will be  
19 some time. I expect to be probably at least an hour,  
20 Mr. Commissioner.  
21 THE COMMISSIONER: Mr. Labow?  
22 MR. LABOW: At least an hour, Mr.  
23 Commissioner, probably two.  
24 THE COMMISSIONER: One to two hours?  
25 MR. LABOW: Yes.  
THE COMMISSIONER: Mr. Tobias?





II2.4

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MR. TOBIAS: Half an hour, Mr.

3

Commissioner.

4

5

THE COMMISSIONER: We are going to  
be in a bit of -- half an hour. Yes?

6

MR. SHANAHAN: About fifteen minutes.

7

MR. LABOW: Mr. Shinehoft expects to  
be at least half an hour, Mr. Commissioner.

8

9

10

11

THE COMMISSIONER: I am not too sure  
I have got everybody now, but if I have, we have six  
hours or pretty close to it. Well, what about  
starting at 9:30 on Monday?

12

13

MR. TOBIAS: If we have a good time  
over the weekend, it is tough to get up early on  
Monday morning.

14

15

16

MS. CRONK: I am very concerned, sir,  
that we are not going to be able to finish the next  
witness next week.

17

18

19

20

THE COMMISSIONER: I think we are  
going to have to --it is going to be a tight schedule  
all next week and I think we may as well start at  
9:30 on Monday. I think Mr. Hunt is the one that has  
to be warned about it.

21

22

MS. CECCHETTO: I will warn him.

23

24

25

THE COMMISSIONER: Will you warn him?  
All right. Thank you.







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II2.5

We will see if we can get through  
Mrs. Radojewski without the need of a stop watch  
on Monday. But on Tuesday, we may have to bring it  
out because otherwise we just are not going to get  
anywhere with Miss Brownless.

Yes, all right, 9:30 Monday morning.

--- whereupon the hearing was adjourned at 4:45 p.m.  
until Monday, the 5th day of March 1984, at  
9:30 a.m.





